AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2022
January 2021 Meeting

TABLE OF CONTENTS

Cover Letter **TAB**

Table of Contents 01

RUC Recommendations Cover Letter 02

Introductory Materials **TAB**

Resource Materials 03

New/Revised CPT Codes CPT 2022 Codes **TAB**

Anesthesia Services for Image-Guided Spinal Procedures (01937, 01938, 01939, 01940, 01941, 01942) 04

Closed Treatment of Nasal Bone Fracture (21315, 21320) 05

Arthrodesis Decompression (22630, 22632, 22633, 22634, 63052, 63053) 06

Percutaneous Cerebral Embolic Protection (33361-33369, 33370) 07

Endovascular Repair of Aortic Coarctation (33894, 33895, 33897) 08

Harvest of Upper Extremity Artery, Endoscopic and Open (33509, 35600) 09

Drug Induced Sleep Endoscopy (DISE) (42975) 10

Periurethral Balloon Continence Device Procedures (53451, 53452, 53453, 53454) 11

Intracranial Laser Interstitial Thermal Therapy (LITT) (61736, 61737) 12

Hypoglossal Nerve Stimulator Services (64582, 64583, 64584) 13

Destruction of Intraosseous Basivertebral Nerve (64628, 64629) 14

Dilation of Aqueous Outflow Canal (66174, 66175) 15

Cataract Removal with Drainage Device Insertion (66982, 66989, 66984, 66991, 66987, 66988) 16

Lacrimal Canaliculus Drug Eluting Implant Insertion (68841) 17

Transcutaneous Passive Implant-Temporal Bone (69714, 69716, 69717, 69719, 69726, 69727) 18

Trabecular Bone Score (TBS) (77089, 77090, 77091, 77092) 19

Pathology Clinical Consult (80503, 80504, 80505, 80506)..... 20

Colon Capsule Endoscopy (91110, 91111, 91113)..... 21

Cardiac Ablation (93653, 93654, 93655, 93656, 93657)..... 22

Outpatient Pulmonary Rehabilitation Services (94625, 94626) 23

Remote Therapeutic Monitoring (98975, 98976, 98977, 98980, 98981) 24

Principal Care Management and Chronic Care Management (99424, 99425, 99426, 99427, 99490, 99439, 99491, 99437, 99487, 99489) 25

CMS Request/Relativity Assessment Identified Codes TAB

Insertion of Interlaminar/Interspinous Device (22867)..... 26

Knee Arthroplasty (27446) 27

COVID-19 Immunization Administration for CPT 2021 TAB

AstraZeneca (0021A & 0022A) and Janssen (0031A) SARS-CoV-2 Immunization Administration.. 28

AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
t (312) 464-5000

February 8, 2021

The Honorable Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Subject: RUC Recommendations

Dear Ms. Richter:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work relative values and direct practice expense inputs to the Centers for Medicare & Medicaid Services (CMS). These recommendations relate to new and revised codes for *CPT 2022*, as well as to existing services identified by the RUC's Relativity Assessment Workgroup and CMS.

Enclosed are the RUC recommendations for all the CPT codes reviewed at the January 13-16, 2021, RUC meeting.

COVID-19 Immunization Administration
The CPT Editorial Panel has implemented CPT codes to describe immunization administration of vaccines developed by each of the following: Pfizer-BioNTech, Moderna, AstraZeneca, and Janssen. RUC recommendations related to Pfizer-BioNTech and Moderna were submitted to CMS in December 2020. We submitted our recommendations for immunization administration of the AstraZeneca in late January 2021 with the RUC comment letter on the Final Rule for 2021. We are submitting the Janssen vaccine administration recommendation, along with all COVID vaccine administration recommendations to date with this submission.

The RUC urges CMS to withdraw the interim final payment rates established for these COVID-19 immunization administration codes and to adopt the RUC-recommended work relative values and direct practice expense inputs instead, providing for resource-based payments.

Additionally, in the Final Rule for 2021, CMS requested the review of immunization administration codes (90460-90470, G0008-G0010). The RUC will review these services for the April 2021 RUC meeting.

CPT 2022 New and Revised Codes – *January 2021 RUC Submission*
The enclosed binder contains RUC recommendations, including those for new and revised CPT codes. **The RUC submits work value and/or practice expense inputs for 102 new/revised/related family CPT codes from the January 2021 meeting, of which 18 are interim recommendations and will be re-reviewed at the April 2021 RUC meeting.**

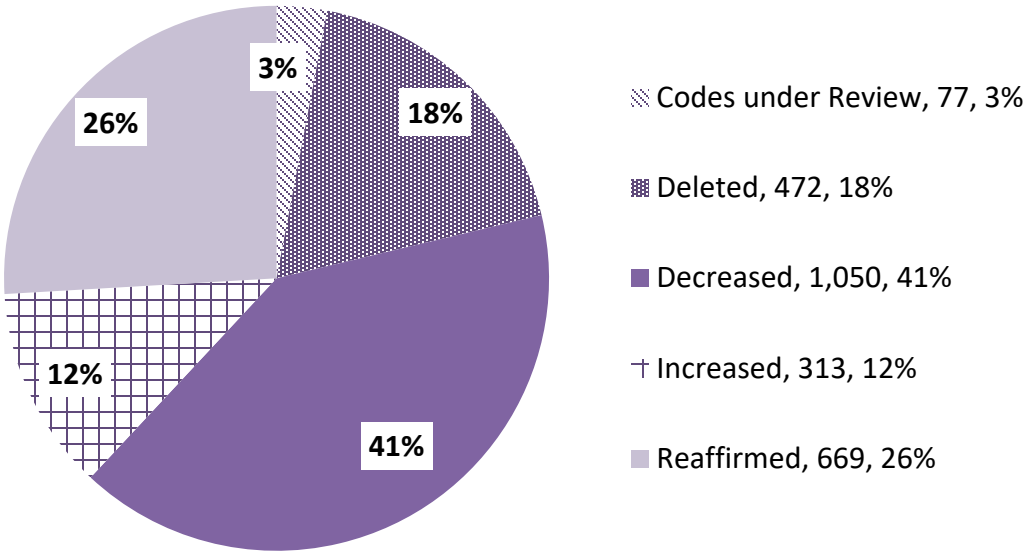
CPT 2022 New and Revised Codes – *Entire CPT 2022 Cycle*
The total number of coding changes for the entire *CPT 2022* cycle is 241, including 99 additions, 63 revisions, and 54 deletions. In addition, 25 new codes were identified as part of the family for review in relationship to the new/revised codes. Of the 187 new/revised/related family CPT codes, 13 services are not payable on the RBRVS or do not require physician work (eg, laboratory services and vaccines) and 22 are Category III codes, and accordingly, the RUC does not submit any recommendations on these codes.

The RUC submits work value and/or practice expense inputs for 152 new/revised/related family CPT codes for the 2022 Medicare Physician Payment Schedule.

Existing Services Identified by RUC and CMS for Review
In addition to the new/revised CPT code submission, the RUC submits recommendations for one service identified by the RUC or CMS as potentially misvalued and reviewed at the January 2021 RUC meeting. **The RUC recommendations are in addition to the 33 recommendations for existing services submitted to CMS following the RUC's April and October 2020 meetings, totaling 34 recommendations identified via the potentially misvalued services project for the 2022 Medicare Physician Payment Schedule.**

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes
Since 2006, the RUC has identified 2,586 potentially misvalued services through objective screening criteria and has completed review of 2,509 of these services. The RUC has recommended that 61% of the services reviewed be decreased or deleted (Figure 1). The RUC has worked vigorously over the past several years to identify and address mis-valuations in the RBRVS through the provision of revised physician time data and resource recommendations to CMS. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services.

Figure 1: AMA/Specialty Society RVS Update Committee (RUC) Potentially Misvalued Services Project



CMS Review

Moderate sedation services (G0500)
The Relativity Assessment Workgroup identified G0500 *Moderate sedation services (G0500) provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)* via the CMS/Other codes with 2019 estimated Medicare utilization over 20,000 screen. The Workgroup requested that action plans be reviewed for these services at the January 2021 meeting to determine if current CPT codes exist to report these services, new CPT codes should be created, or the G code should be surveyed. In December 2020, the RUC recommended to maintain the value for this service. However, the specialty societies identified an error in the physician time file. **The specialty societies indicated that they communicated with CMS on January 29, 2021, clarifying the intra-service time error in the physician time file (lists 12 minutes but should be 5 minutes intra-service time).**

*Transcatheter therapy, embolization (*75894)
CPT code 75894 was identified in February 2010 via the Code Reported Together 75% or More screen. The RUC accepted the specialty societies' recommendation to refer to the CPT Editorial Panel to address any duplication when this service is reported with 37201 on the same date by the same physician. Previous notes indicated that ACC submitted a CPT Code Change Application for February 2013 CPT related to 75894, creating a new code for a particular cardiac procedure that is currently reported using that code; however, code 75894 was not specifically addressed. At the January 2013 RUC meeting, the RUC recommended that 75894 be referred to CPT for revision. CPT code 75894 has not been included in any coding change proposals to date and the specialty society was requested to submit an action plan indicating why a code change proposal has not been submitted as well as the next steps to address this service. The specialty societies indicated that the utilization for this service will go down after the other coding changes take effect. The Relativity Assessment Workgroup recommended reviewing this service in two years after more utilization data was available (October 2018). In October 2018, the Workgroup noted that utilization decreased appropriately after code bundling solutions. However, this service is currently CMS/Other source and has never been RUC surveyed. Therefore, the Workgroup requested an action plan for January 2019 to determine whether to survey what remains in this service currently or delete this service. In January 2019, the Workgroup recommended to review in two years. This service represents the residual that remains after bundling it to other various services. The RUC noted that when it reviews this service again in two years that "varicose veins of lower extremities" should no longer be the primary diagnosis.

In December 2020, the Relativity Assessment Workgroup reviewed this service and noted the Medicare utilization for CPT code 75894 has decreased from 30,644 in 2009 to 9,539 in 2019e. The majority of the 2019e Medicare utilization for CPT code 75894 is the reported by the professional component only (8,456 or 89%) and "varicose veins of the lower extremities" no longer appears to be a primary diagnosis for this service.

CPT Code 75894 Top Diagnoses for the Professional Component only:

I67	Other cerebrovascular diseases	49.4%
I60	Nontraumatic subarachnoid hemorrhage	16.5%
R04	Hemorrhage from respiratory passages	9.1%
I72	Other aneurysm	4.3%

CPT Code 75894 Top Diagnoses for Global + PC:

I67	Other cerebrovascular diseases	45.3%
I60	Nontraumatic subarachnoid hemorrhage	15.2%
R04	Hemorrhage from respiratory passages	8.4%
I83	Varicose veins of lower extremities	7.3%

In December 2020, the Relativity Assessment Workgroup noted that code 75894 is no longer performed for varicose veins of lower extremities in the majority, professional component only, of these cases. The RUC recommends that these services be maintained and removed from this screen. The specialty societies noted that of the 95% of the total 2018 Medicare office claims were reported by only 6 providers. The RUC requests that CMS investigate this possible incorrect reporting.

Practice Expense Subcommittee

The attached materials include direct practice expense input (medical staff, supplies and equipment) recommendations for each code reviewed. As a reminder, cost estimates for proposed new clinical staff types, medical supplies and medical equipment (not listed as part of the CMS labor, supply, and equipment lists) are based on provided source(s), such as paid invoices and may not reflect the wholesale prices, quantity, cash discounts, prices for used equipment or any other factors that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing.

Office Visits Included in Codes with a Surgical Global Period

The RUC strongly believes that it is appropriate to apply the increased valuation of the office visits to the visits incorporated in the surgical global packages. However, CMS proposes not to apply the office visit increases to the visits bundled into global surgery payment. An example of why this policy is flawed was raised during discussion of CPT code 67141 *Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy* (RUC recommended work RVU = 2.53 and 2-99213 office visits) at the October 2020 RUC meeting. The RUC questioned whether the specialties had considered changing the global period to a 000-day global given that the intensity will be low and the office visits in 2021 will be of a different value. The specialties explained it is routine and typical that the two postoperative visits occur as part of the work within the 10 days after the procedure. The survey code is a good fit for the 010-day global and is in alignment with the other retinal laser codes and ophthalmic laser codes for other diseases. Relativity is therefore better maintained by keeping as a 010-day global even though the intensity is low. The RUC noted that these codes are being valued too low considering that office visits for the surgical global period are not going to change. The 99213 office visit in 2021 is valued at 1.30 RVUs, therefore, two 99213 office visits are valued higher than this code. It is disadvantageous to the eye surgeons and an example of the why the policy from CMS is flawed. The Agency implies that the physician work for office visits is not the same when performed in a surgical global period. **As stated in the RUC comment letter to CMS on the CY 2021 Proposed Rule, the**

RUC recommends that CMS apply the office visit increases uniformly across all services and specialties. CMS should not hold specific specialties to a different standard. The RUC urges CMS to apply the office visit increases to the office visits included in surgical global payment, as it has done historically.

Enclosed Recommendations and Supporting Materials:

- RUC Recommendation Status Report for New and Revised Codes for CPT 2022.
- RUC Recommendation Summary of Existing Codes Identified by CMS or the RAW.
- RUC Recommendation Progress and Status Reports for 2,586 services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued.
- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.
- Physician Time File: A list of the physician time data for each of the CPT codes reviewed at the January 2021 RUC meeting.
- Pre-Service and Post-Service Time Packages Definitions: The RUC developed physician pre-service and post-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service and post-service time data for all codes reviewed by the RUC.
- PLI Crosswalk Table: The RUC has committed to selecting appropriate professional liability insurance crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.
- BETOS Assignment Table: The RUC, for each meeting, provides CMS with suggested BETOS classification assignments for new/revised codes. Furthermore, if an existing service is reviewed and the specialty believes the current assignment is incorrect, this table will reflect the desired change.
- Utilization Crosswalk Table: A table estimating the flow of claims data from existing codes to the new/revised codes. This information is used to project the work relative value savings to be included in the 2022 conversion factor increase.
- New Technology List and Flow Chart: In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 716 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services and the date of review is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.
- RUC Recommendations on Modifications to Visits in the Global Period – January 2021.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at sherry.smith@ama-assn.org.

Sincerely,



Peter K. Smith, MD

Enclosures

cc: RUC Participants
Perry Alexion, MD
Larry Chan
Arkaprava Deb, MD
Edith Hambrick, MD
Ryan Howe
Christiane LaBonte
Scott Lawrence
Karen Nakano, MD
Michael Soracoe
Gift Tee
Emily Yoder

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2022

RESOURCE MATERIALS
TABLE OF CONTENTS

RUC Recommendations Status Report: New and Revised Codes 01

RUC Recommendations for Existing Codes.....02

RUC Relativity Assessment Workgroup Progress Report.....03

CMS Requests and Relativity Assessment Workgroup Status Report and Data 04

RUC Referrals to CPT Editorial Panel.....05

RUC Referrals to CPT Assistant 06

Physician Time File.....07

Pre-Service Time Packages Table 08

Post-Service Time Packages Table.....09

PLI Crosswalk Table.....10

BETOS Assignment Table 11

Utilization Data Crosswalk 12

New Technology/New Services List.....13

New Technology/New Services Timeline 14

Specialty and Acronym List.....15

RUC Recommendations on Modifications to Visits in Global Period 16

CPT 2022 RUC and HCPAC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
0191T	XXX	D	Oct. 2020	37	Cataract Removal with Drainage Device Insertion		Cat III						☐		☐
01935	XXX	D	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures		January 2021						☑		☐
01936	XXX	D	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures		January 2021						☑		☐
01XX2	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H1	January 2021	4	ASA	4.00	4.00		☑		☐
01XX3	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H2	January 2021	4	ASA	4.00	4.00		☑		☐
01XX4	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H3	January 2021	4	ASA	5.00	4.00		☑		☐
01XX5	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H4	January 2021	4	ASA	4.00	4.00		☑		☐
01XX6	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H5	January 2021	4	ASA	7.00	6.00		☑		☐
01XX7	XXX	N	Oct. 2020	15	Anesthesia Services for Image-Guided Spinal Procedures	H6	January 2021	4	ASA	7.00	6.00		☑		☐
0290T	ZZZ	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0355T	YYY	D	Oct. 2020	58	Colon Capsule Endoscopy		Cat III						☐		☐
0356T	YYY	D	Oct. 2020	38	Lacrimal Canaliculus Drug Eluting Implant Insertion		Cat III						☐		☐
0376T	XXX	D	Oct. 2020	37	Cataract Removal with Drainage Device Insertion		Cat III						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
0423T	XXX	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0451T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0452T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0453T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0454T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0455T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0456T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0457T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0458T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0459T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0460T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0461T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0462T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0463T	YYY	D	Feb. 2021	46	Category III Sundown		Cat III						☐		☐
0466T	YYY	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐
0467T	YYY	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐
0468T	YYY	D	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Cat III						☐		☐
050XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
051XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
052XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
053XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
0548T	YYY	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
0549T	YYY	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
054XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
0550T	YYY	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
0551T	YYY	D	Oct. 2020	30	Periurethral Balloon Continence Device Procedures		Cat III						☐		☐
055XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
056XT	XXX	N	Feb. 2021	41	Cat III Histotripsy		Cat III						☐		☐
057XT	XXX	N	Feb. 2021	45	Cat III Therapeutic Ultrafiltration		Cat III						☐		☐
058XT	XXX	N	Feb. 2021	42	Cat III Amblyopia Training Services		Cat III						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
059XT	XXX	N	Feb. 2021	42	Cat III Amblyopia Training Services		Cat III						☐		☐
060XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
061XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
062XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
063XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
064XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
065XT	XXX	N	Feb. 2021	40	Cat III Synchronized Diaphragmatic Stimulation to Improve Cardiac Output		Cat III						☐		☐
06X0T	XXX	N	Feb. 2021	19	Cat III Dual Energy Tissue Remodeling		Cat III						☐		☐
0X12T	090	N	Oct. 2020	37	Cat III Cataract Removal with Drainage Device Insertion		Cat III						☐	Contractor Price	☐
0X33T	XXX	N	Feb. 2021	43	Cat III Quantitative Ultrasound Tissue Characterization (Non-Elastographic)		Cat III						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
0X34T	XXX	N	Feb. 2021	43	Cat III Quantitative Ultrasound Tissue Characterization (Non-Elastographic)		Cat III						☐		☐
0X36T	XXX	N	Feb. 2021	44	Cat III Automated Analysis of an Existing Computed Tomography Study		Cat III						☐		☐
0X45T	XXX	N	Feb. 2021	20	Cat III Thyroid Nodule Laser Ablation		Cat III						☐		☐
12001	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			0.84	0.84	Yes	☑		☐
12002	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.14	1.14	Yes	☑		☐
12004	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.44	1.44	Yes	☑		☐
12005	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.97	1.97	Yes	☑		☐
12006	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.39	2.39	Yes	☑		☐
12007	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.90	2.90	Yes	☑		☐
12011	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.07	1.07	Yes	☑		☐
12013	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.22	1.22	Yes	☑		☐
12014	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.57	1.57	Yes	☑		☐
12015	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			1.98	1.98	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
12016	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			2.68	2.68	Yes	☑		☐
12017	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			3.18	3.18	Yes	☑		☐
12018	000	R	May 2020	10	Integumentary Simple Repair Guide Revision		Editorial			3.61	3.61	Yes	☑		☐
21310	000	D	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture		January 2021						☑		☐
21315	000	R	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture	I1	January 2021	5	AAOHNS, ASPS	2.00	2.00		☑		☐
21320	000	R	Oct. 2020	18	Closed Treatment of Nasal Bone Fracture	I2	January 2021	5	AAOHNS, ASPS	2.33	2.33		☑		☐
22600	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial	6		17.40	17.40	Yes	☑		☐
22610	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial	6		17.28	17.28	Yes	☑		☐
22612	090	R	Oct. 2020	20	Arthrodesis Decompression		Editorial	6		23.53	23.53	Yes	☑		☐
22614	ZZZ	R	Oct. 2020	20	Arthrodesis Decompression		Editorial	6		6.43	6.43	Yes	☑		☐
22630	090	F	Oct. 2020	20	Arthrodesis Decompression	J1	January 2021	6	AANS, AAOS, CNS, ISASS, NASS	22.09	22.09	Yes	☑	Interim - survey for April 2021	☐
22632	ZZZ	F	Oct. 2020	20	Arthrodesis Decompression	J2	January 2021	6	AANS, AAOS, CNS, ISASS, NASS	5.22	5.22	Yes	☑	Interim - survey for April 2021	☐
22633	090	R	Oct. 2020	20	Arthrodesis Decompression	J3	January 2021	6	AANS, AAOS, CNS, ISASS, NASS	27.75	27.75	Yes	☑	Interim - survey for April 2021	☐
22634	ZZZ	R	Oct. 2020	20	Arthrodesis Decompression	J4	January 2021	6	AANS, AAOS, CNS, ISASS, NASS	8.16	8.16	Yes	☑	Interim - survey for April 2021	☐
33361	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K1	January 2021	7	ACC, SCAI	22.47	22.47	Yes	☑		☐
33362	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K2	January 2021	7	ACC, SCAI	24.54	24.54	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
33363	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K3	January 2021	7	ACC, SCAI	25.47	25.47	Yes	☑		☐
33364	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K4	January 2021	7	ACC, SCAI	25.97	25.97	Yes	☑		☐
33365	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K5	January 2021	7	ACC, SCAI	26.59	26.59	Yes	☑		☐
33366	000	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K6	January 2021	7	ACC, SCAI	29.35	29.35	Yes	☑		☐
33367	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K7	January 2021	7	ACC, SCAI	11.88	11.88	Yes	☑		☐
33368	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K8	January 2021	7	ACC, SCAI	14.39	14.39	Yes	☑		☐
33369	ZZZ	F	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K9	January 2021	7	ACC, SCAI	19.00	19.00	Yes	☑		☐
33746	ZZZ	R	Feb. 2021	EC-D	Cardiac Catheterization for Congenital Defects		Editorial			8.00	8.00	Yes	☑		☐
338X0	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L3	January 2021	8	ACC, SCAI, SIR	17.00	14.00		☑		☐
338X1	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L1	January 2021	8	ACC, SCAI, SIR	23.30	21.70		☑		☐
338X2	000	N	Oct. 2020	24	Endovascular Repair of Aortic Coarctation	L2	January 2021	8	ACC, SCAI, SIR	20.00	17.97		☑		☐
33XX3	090	N	May 2020	12	Exclusion of Left Atrial Appendage	A1	October 2020	5	AATS, STS	18.50	18.50		☑		☑
33XX4	ZZZ	N	May 2020	12	Exclusion of Left Atrial Appendage	A2	October 2020	5	AATS, STS	3.00	2.50		☑		☑
33XX5	090	N	May 2020	12	Exclusion of Left Atrial Appendage	A3	October 2020	5	AATS, STS	15.73	14.31		☑		☑
33XXX	ZZZ	N	Oct. 2020	23	Percutaneous Cerebral Embolic Protection	K10	January 2021	7	ACC, SCAI	3.43	2.50		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
35600	XXX	R	May 2020	13	Harvest of Upper Extremity, Endoscopic and Open	B2	January 2021	9	AAPA, AATS, ANA, STS	4.00	4.00		☑		☐
35XX0	XXX	N	May 2020	13	Harvest of Upper Extremity, Endoscopic and Open	B1	January 2021	9	AAPA, AATS, ANA, STS	3.75	3.75		☑		☑
42XXX	000	N	Oct. 2020	27	Drug Induced Sleep Endoscopy (DISE)	M1	January 2021	10	AAOHNS	2.19	1.90		☑	Interim - survey for April 2021	☐
434XX	090	N	May 2020	14	Per-Oral Endoscopic Myotomy (POEM)	C1	October 2020	7	AATS, ACG, AGA, ASGE, SAGES, STS ACG AGA ASGE SAGES STS	15.50	15.50		☑		☑
43850	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
43855	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
53XX1	010	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N1	January 2021	11	AUA				☑	Contractor Price	☑
53XX2	010	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N2	January 2021	11	AUA				☑	Contractor Price	☑
53XX3	000	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N3	January 2021	11	AUA				☑	Contractor Price	☑
53XX4	000	N	Oct. 2020	30	Periurethral Balloon Continence Device Procedures	N4	January 2021	11	AUA				☑	Contractor Price	☑
54340	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			9.71	9.71	Yes	☑		☐
54344	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			17.06	17.06	Yes	☑		☐
54348	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			18.32	18.32	Yes	☑		☐
54352	090	R	Oct. 2020	31	Repair of Hypospadias		Editorial			26.13	26.13	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
617X1	000	N	Oct. 2020	33	Intracranial Laser Interstitial Thermal Therapy (LITT)	O1	January 2021	12	AANS, CNS	20.00	20.00		☑		☑
617X2	000	N	Oct. 2020	33	Intracranial Laser Interstitial Thermal Therapy (LITT)	O2	January 2021	12	AANS, CNS	24.00	24.00		☑		☑
630X1	ZZZ	N	Oct. 2020	20	Arthrodesis Decompression	J6	January 2021	6	AANS, AAOS, CNS, ISASS, NASS	4.70	4.44		☑	Interim - survey for April 2021	☐
630XX	ZZZ	N	Oct. 2020	20	Arthrodesis Decompression	J5	January 2021	6	AANS, AAOS, CNS, ISASS, NASS	5.55	5.55		☑	Interim - survey for April 2021	☐
63194	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
63195	090	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
64568	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			9.00	9.00	Yes	☑		☐
64569	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			11.00	11.00	Yes	☑		☐
64570	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			9.10	9.10	Yes	☑		☐
64575	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			4.42	4.42	Yes	☑		☐
64580	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			4.19	4.19	Yes	☑		☐
64581	090	R	Oct. 2020	35	Hypoglossal Nerve Stimulator Services		Editorial			12.20	12.20	Yes	☑		☐
645X1	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P1	January 2021	13	AAOHNS	16.00	16.00		☑		☐
645X2	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P2	January 2021	13	AAOHNS	17.04	16.50		☑		☐
645X3	090	N	Oct. 2020	35	Hypoglossal Nerve Stimulator Services	P3	January 2021	13	AAOHNS	14.00	14.00		☑		☐
646X0	010	N	Oct. 2020	19	Destruction of Intraosseous Basivertebral Nerve	Q1	January 2021	14	AAPM, AAPM&R, ASIPP, ISASS, NASS, SIS	9.75	8.25		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
646X1	ZZZ	N	Oct. 2020	19	Destruction of Intraosseous Basivertebral Nerve	Q2	January 2021	14	AAPM, AAPM&R, ASIPP, ISASS, NASS, SIS	4.87	4.87		☑		☑
66174	090	R	Oct. 2020	36	Dilation of Aqueous Outflow Canal	R1	January 2021	15	AAO	8.60	8.53		☑		☐
66175	090	F	Oct. 2020	36	Dilation of Aqueous Outflow Canal	R2	January 2021	15	AAO	10.25	10.25		☑		☐
66982	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S1	January 2021	16	AAO, ASCRS	10.25	10.25	Yes	☑		☐
66984	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S4	January 2021	16	AAO, ASCRS	7.35	7.35	Yes	☑		☐
66987	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S3	January 2021	16	AAO, ASCRS	13.15	13.15	Yes	☑		☐
66988	090	F	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S5	January 2021	16	AAO, ASCRS	10.25	10.25	Yes	☑		☐
669X1	090	N	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S2	January 2021	16	AAO, ASCRS	12.13	12.13		☑		☑
669X2	090	N	Oct. 2020	37	Cataract Removal with Drainage Device Insertion	S6	January 2021	16	AAO, ASCRS	11.05	9.23		☑		☑
67141	010	R	May 2020	16	Retinal Detachment Prophylaxis	D1	October 2020	8	AAO, ASRS	2.53	2.53		☑		☐
67145	010	R	May 2020	16	Retinal Detachment Prophylaxis	D2	October 2020	8	AAO, ASRS	2.53	2.53		☑		☐
68XXX	000	N	Oct. 2020	38	Lacrimal Canaliculus Drug Eluting Implant Insertion	T1	January 2021	17	AAO, ASCRS	0.49	0.49		☑		☑
69714	090	R	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U1	January 2021	18	AAOHNS	11.00	8.69		☑	Interim - survey for April 2021	☐
69715	090	D	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone		January 2021						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
69717	090	R	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U3	January 2021	18	AAOHNS	11.48	8.80		☑	Interim - survey for April 2021	☐
69718	090	D	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone		January 2021						☑		☐
69X50	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U2	January 2021	18	AAOHNS	12.00	9.77		☑	Interim - survey for April 2021	☐
69X51	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U4	January 2021	18	AAOHNS	12.00	9.77		☑	Interim - survey for April 2021	☐
69X52	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U5	January 2021	18	AAOHNS	10.00	5.93		☑	Interim - survey for April 2021	☐
69X53	090	N	Oct. 2020	39	Transcutaneous Passive Implant-Temporal Bone	U6	January 2021	18	AAOHNS	10.98	7.13		☑	Interim - survey for April 2021	☐
72275	XXX	D	Oct. 2020	40	Epidurography		Deleted						☑		☐
75573	XXX	R	May 2020	18	CT of the Heart		Editorial			2.55	2.55	Yes	☑		☐
76101	XXX	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
76102	XXX	D	Oct. 2020	42	Deletion of Codes with Low Utilization		Deleted						☑		☐
77X01	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V1	January 2021	19	ACR	0.20	0.20		☑		☑
77X02	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V2	January 2021	19	ACR	0.00	0.00		☑	PE Only	☑
77X03	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V3	January 2021	19	ACR	0.00	0.00		☑	PE Only	☑
77X04	XXX	N	Oct. 2020	43	Trabecular Bone Score (TBS)	V4	January 2021	19	ACR	0.20	0.20		☑		☑
80500	XXX	D	Oct. 2020	50	Pathology Clinical Consult		Deleted						☑		☐
80502	XXX	D	Oct. 2020	50	Pathology Clinical Consult		Deleted						☑		☐
80XX0	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W1	January 2021	20	CAP	0.50	0.50		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
80XX1	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W2	January 2021	20	CAP	0.91	0.91		☑		☐
80XX2	XXX	N	Oct. 2020	50	Pathology Clinical Consult	W3	January 2021	20	CAP	1.80	1.80		☑		☐
80XX3	ZZZ	N	Oct. 2020	50	Pathology Clinical Consult	W4	January 2021	20	CAP	0.80	0.80		☑		☐
815X0	XXX	N	Oct. 2020	45	MAAA Allograft Rejection Risk		CLFS						☐		☐
815X1	XXX	N	Oct. 2020	46	MAAA Breast Cancer Metastasis RNA Sequencing		CLFS						☐		☐
8352X	XXX	N	Feb. 2021	23	Light Chains (Kappa and Lambda) Testing		CLFS						☐		☐
835X1	XXX	N	Feb. 2021	22	Interleukin 6 Immunoassay		CLFS						☐		☐
860X1	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
860X2	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
860XX	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
862X0	XXX	N	Feb. 2021	25	Endomysial Antibody (EMA) Ig Test-Celiac Dx		CLFS						☐		☐
862X1	XXX	N	Feb. 2021	27	Tissue Transglutaminase (TTG) Ig Test-Celiac Dx		CLFS						☐		☐
862XX	XXX	N	Feb. 2021	26	Deamidated Gliadin Peptide (DGP) Ig Test-Celiac Dx		CLFS						☐		☐
863X1	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐
863XX	XXX	N	Feb. 2021	24	Neuromyelitis Optica (NMO) Antibody Testing		CLFS						☐		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
9074X	XXX	N	Feb. 2021	28	Hepatitis B 3-Antigen Vaccine		Vaccine						☐		☐
90785	ZZZ	R	Oct. 2020	55	Psychiatric Interactive Complexity Instructions		Editorial			0.33	0.33	Yes	☑		☐
91110	XXX	F	Oct. 2020	58	Colon Capsule Endoscopy	X1	January 2021	21	ACG, AGA, ASGE	2.24	2.24		☑		☐
91111	XXX	F	Oct. 2020	58	Colon Capsule Endoscopy	X2	January 2021	21	ACG, AGA, ASGE	1.00	1.00	Yes	☑		☐
9111X	XXX	N	Oct. 2020	58	Colon Capsule Endoscopy	X3	January 2021	21	ACG, AGA, ASGE	2.41	2.41		☑		☑
92065	XXX	R	May 2020	37	Orthoptic Training	E1	October 2020	9	AAO, AOA				☑	Refer to CPT	☐
92559	XXX	D	Feb. 2021	34	Vestibular and Audiologic Function Test		Deleted						☑		☐
92560	XXX	D	Feb. 2021	34	Vestibular and Audiologic Function Test		Deleted						☑		☐
92561	XXX	D	Feb. 2021	34	Vestibular and Audiologic Function Test		Deleted						☑		☐
92564	XXX	D	Feb. 2021	34	Vestibular and Audiologic Function Test		Deleted						☑		☐
92626	XXX	R	May 2020	38	Evaluation of Auditory Function		Editorial			1.40	1.40	Yes	☑		☐
92627	ZZZ	R	May 2020	38	Evaluation of Auditory Function		Editorial			0.33	0.33	Yes	☑		☐
92651	XXX	R	Feb. 2021	33	Auditory Evoked Potentials		Editorial			1.00	1.00	Yes	☑		☐
92652	XXX	R	Feb. 2021	33	Auditory Evoked Potentials		Editorial			1.50	1.50	Yes	☑		☐
92653	XXX	R	Feb. 2021	33	Auditory Evoked Potentials		Editorial			1.05	1.05	Yes	☑		☐
933X0	ZZZ	N	May 2020	39	3D Imaging of Cardiac Structures	G1	October 2020	11	ACC, ASE	0.50	0.50		☑		☑
93530	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93531	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93532	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93533	000	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93561	ZZZ	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93562	ZZZ	D	May 2020	40	Cardiac Catheterization for Congenital Defects		October 2020	10					☑		☐
93653	000	R	Oct. 2020	61	Cardiac Ablation	Y1	January 2021	22	ACC, HRS	18.49	18.49		☑	Interim - survey for April 2021	☐
93654	000	R	Oct. 2020	61	Cardiac Ablation	Y2	January 2021	22	ACC, HRS	19.75	19.75	Yes	☑	Interim - survey for April 2021	☐
93655	ZZZ	F	Oct. 2020	61	Cardiac Ablation	Y3	January 2021	22	ACC, HRS	8.00	6.50		☑	Interim - survey for April 2021	☐
93656	000	R	Oct. 2020	61	Cardiac Ablation	Y4	January 2021	22	ACC, HRS	24.20	20.00		☑	Interim - survey for April 2021	☐
93657	ZZZ	F	Oct. 2020	61	Cardiac Ablation	Y5	January 2021	22	ACC, HRS	8.00	6.50		☑	Interim - survey for April 2021	☐
93662	ZZZ	R	Feb. 2021	EC-C	Intracardiac Echo		Editorial			0.00	0.00	Yes	☑		☐
93662	ZZZ	R	May 2020	41	Intracardiac Echo		Editorial			0.00	0.00	Yes	☑		☐
93X1X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F1	October 2020	10	AAP, ACC, SCAI	3.99	3.99		☑		☑
93X2X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F2	October 2020	10	AAP, ACC, SCAI	6.10	6.10		☑		☑
93X3X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F3	October 2020	10	AAP, ACC, SCAI	6.00	6.00		☑		☑
93X4X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F4	October 2020	10	AAP, ACC, SCAI	7.91	7.91		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
93X5X	000	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F5	October 2020	10	AAP, ACC, SCAI	11.74	9.99		☑		☑
93X6X	ZZZ	N	May 2020	40	Cardiac Catheterization for Congenital Defects	F6	October 2020	10	AAP, ACC, SCAI	2.00	1.75		☑		☑
946X1	XXX	N	Oct. 2020	62	Outpatient Pulmonary Rehabilitation Services	Z1	January 2021	23	ATS, CHEST	0.55	0.55		☑		☑
946X2	XXX	N	Oct. 2020	62	Outpatient Pulmonary Rehabilitation Services	Z2	January 2021	23	ATS, CHEST	0.69	0.69		☑		☑
95943	XXX	D	Oct. 2020	65	Autonomic Function Testing		Deleted						☐		☐
989X1	XXX	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA1	January 2021	24	AAP, AAPM&R, ANA, APTA	0.00	0.00		☑	PE Only	☑
989X2	XXX	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA2	January 2021	24	AAP, AAPM&R, ANA, APTA	0.00	0.00		☑	PE Only	☑
989X3	XXX	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA3	January 2021	24	AAP, AAPM&R, ANA, APTA	0.00	0.00		☑	PE Only	☑
989X4	XXX	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA4	January 2021	24	AAP, AAPM&R, ANA, APTA	0.62	0.62		☑		☑
989X5	ZZZ	N	Oct. 2020	11,12	Remote Therapeutic Monitoring	AA5	January 2021	24	AAP, AAPM&R, ANA, APTA	0.61	0.61		☑		☑
99211	XXX	R	Feb. 2021	06	Office Visit 99211 Editorial Revision		Editorial			0.18	0.18	Yes	☑		☐
99354	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		2.33	2.33	Yes	☑		☐
99355	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.77	1.77	Yes	☑		☐
99356	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.71	1.71	Yes	☑		☐
99357	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		1.71	1.71	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99358	XXX	R	May 2020	EC-G	Prolonged Services	U1	October 2020	12	AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA	2.10	2.10	Yes	☑	Refer to CPT, 2023 cycle	☐
99359	ZZZ	R	May 2020	EC-G	Prolonged Services	U2	October 2020	12	AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA	1.00	1.00	Yes	☑	Refer to CPT, 2023 cycle	☐
99439	ZZZ	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB6	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	0.70	0.70		☑		☑
99483	XXX	R	Feb. 2021	EC-E	Semicolons in Stand Alone Codes		Editorial			3.80	3.80	Yes	☑		☐
99484	XXX	R	Feb. 2021	EC-E	Semicolons in Stand Alone Codes		Editorial			0.61	0.61	Yes	☑		☐
99487	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB9	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.81	1.81		☑		☑
99489	ZZZ	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB10	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99490	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB5	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99491	XXX	F	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB7	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.50	1.50		☑		☑
99492	XXX	R	Feb. 2021	EC-E	Semicolons in Stand Alone Codes		Editorial			1.88	1.88	Yes	☑		☐
99493	XXX	R	Feb. 2021	EC-E	Semicolons in Stand Alone Codes		Editorial			2.05	2.05	Yes	☑		☐
99X21	ZZZ	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB8	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99X22	XXX	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB1	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.45	1.45		☑		☑
99X23	ZZZ	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB2	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99X24	XXX	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB3	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	1.00	1.00		☑		☑
99X25	ZZZ	N	Oct. 2020	13	Principal Care Management and Chronic Care Management	BB4	January 2021	25	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA	0.62	0.71		☑		☑
99XXX	ZZZ	R	May 2020	EC-G	Prolonged Services		Editorial	12		0.61	0.61	Yes	☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
G0424	XXX	D	Oct. 2020	62	Outpatient Pulmonary Rehabilitation Services		Deleted						☐	RUC recommends deletion	☐
G2064	XXX	D	Oct. 2020	13	Principal Care Management and Chronic Care Management		Deleted						☐	RUC recommends deletion	☐
G2065	XXX	D	Oct. 2020	13	Principal Care Management and Chronic Care Management		Deleted						☐	RUC recommends deletion	☐

RUC Recommendations for CMS Requests & Relativity Assessment Identified Code - January 2021

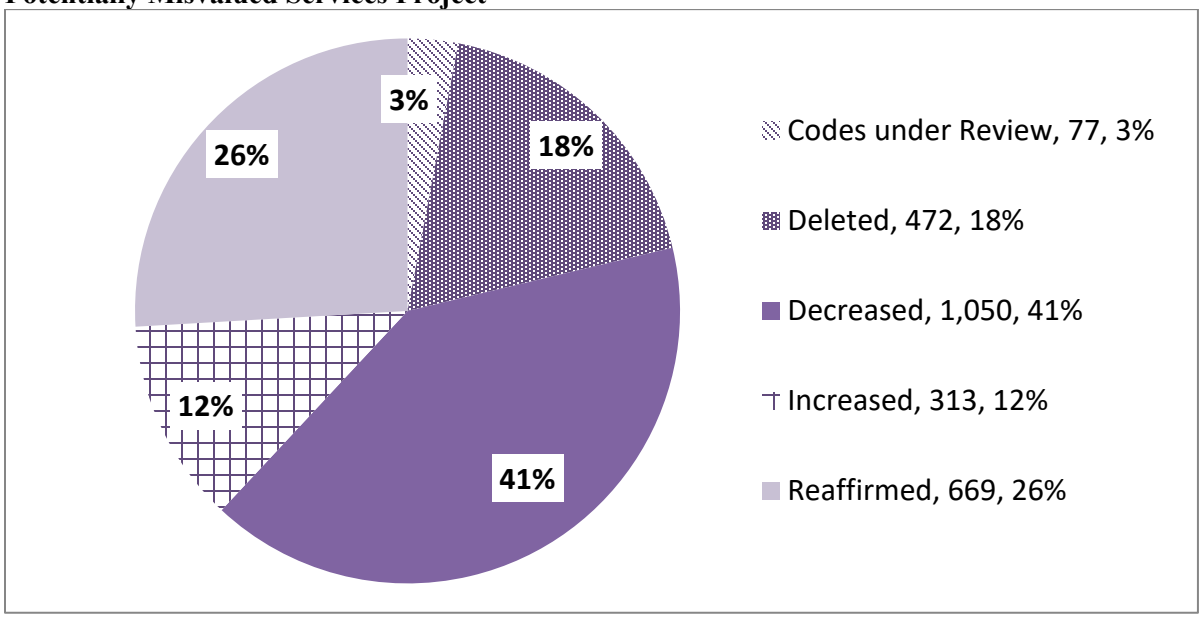
CPT Code	Long Descriptor	Issue	Tab	RUC Recommendation	CMS Request - Final Rule for 2021	Site of Service Anomaly
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Insertion of Interlaminar/Interspinous Device	26	15.00	X	
27746	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	Knee Arthroplasty	27	Survey for April 2021		X

The RUC Relativity Assessment Workgroup Progress Report

In 2006, the AMA/Specialty Society RVS Update Committee (RUC) established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. Since the inception of the Relativity Assessment Workgroup, the Workgroup and the Centers for Medicare and Medicaid Services (CMS) have identified nearly 2,600 services through over 20 different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the "new technology" list of services that will be re-reviewed by the RUC as reporting and cost data become available.

To provide Medicare with reliable data on how physician work has changed over time, the RUC, with more than 300 experts in medicine and research, are examining 2,586 potentially misvalued services accounting for $45 billion in Medicare spending. The update committee has recommended reductions and deletions to 1,522 services, redistributing $5 billion annually. Here are the outcomes for the committee's review of 2,586 codes:

Potentially Misvalued Services Project



Source: American Medical Association

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the appropriate specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT® code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which currently contains 716 services. In September 2010, the re-review cycle began and since then the RUC has recommended 50 services to be re-examined. The remaining services are rarely performed (i.e., less than 500 times per year in the Medicare population) and will not be further

examined. The Workgroup will continue to review the remaining 244 services every October after three years of Medicare claims data is available for each service.

Methodology Improvements
The RUC implemented process improvements to methodology following its October 2013 meeting. The process improvements are designed to strengthen the RUC's primary mission of providing the final RVS update recommendations to the Centers for Medicare and Medicaid Services.

In the area of methodology, the RUC is continuously improving its processes to ensure that it is best utilizing reliable, extant data. At its most recent meeting, the RUC increased the minimum number of respondents required for each survey of commonly performed codes:

- For services performed 1 million or more times per year in the Medicare population, at least 75 physicians must complete the survey.
- For services performed from 100,000 to 999,999 times annually, at least 50 physicians will be required.

Further strengthening its methodology, the RUC also announced that specialty societies will move to a centralized online survey process, which will be coordinated by the AMA and will utilize external expertise to ensure survey and reporting improvements.

Site of Service Anomalies
The Workgroup initiated its effort by reviewing services with anomalous sites of service when compared to Medicare utilization data. Specifically, these services are performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within their global period.

The RUC identified 194 services through the site of service anomaly screen. The RUC required the specialties to resurvey 129 services to capture the appropriate physician work involved. These services were reviewed by the RUC between April 2008 and February 2011. CMS implemented 124 of these recommendations in the 2009, 2010 and 2011 Medicare Physician Payment Schedules. The RUC submitted another five recommendations as well as re-reviewed and submitted 44 recommendations to previously reviewed site of service identified codes to CMS for the 2012 Medicare Physician Payment Schedule.

Of the remaining 65 services that were not re-surveyed, the RUC modified the discharge day management for 46 services, maintained three codes and removed two codes from the screen as the typical patient was not a Medicare beneficiary and would be an inpatient. The CPT® Editorial Panel deleted 14 codes. The RUC completed review of services under this initial screen.

During this review, the RUC uncovered several services that are reported in the outpatient setting, yet, according to several expert panels and survey data from physicians who perform the procedure, the service, typically requires a hospital stay of greater than 23 hours. The RUC maintains that physician work that is typically performed, such as visits on the date of service and discharge work the following day, should be included within the overall valuation. Subsequent observation day visits and discharge day management service are appropriate proxies for this work.

The RUC will reassess the data each year going forward to determine if any new site of service anomalies arise. In 2015, the RUC identified three services in which the Medicare data from 2011-2013 indicated it was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period. These services were referred to CPT and recommendations were submitted to CMS for the 2018 Medicare Physician Payment Schedule.

In 2016, the RUC identified one site of service anomaly CPT code and submitted the recommendation to CMS for the 2019 Medicare Physician Payment Schedule. In 2017, the RUC identified one site of service anomaly CPT code which was revised at the CPT Editorial Panel and the RUC submitted recommendations for the 2020 Medicare Physician Payment Schedule.

In 2018, the RUC also performed a site-of-service anomaly screen based on the review of three years of data (2015, 2016 and 2017e) for services with utilization over 10,000 in which a service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included. One service was identified via this screen and another identified for the outpatient site of service anomaly screen. The RUC submitted this recommendation for the 2021 Medicare Physician Payment Schedule.

In 2019, the RUC lowered the threshold for site-of-service anomalies based on the review of three years of data (2016, 2017 and 2018e) for services with utilization over 5,000 in the outpatient setting more than 50% of the time but includes inpatient hospital Evaluation and Management services within the global period. The RUC identified nine services, expanding to 10 services to include the family of services. The RUC referred three codes to the CPT Editorial Panel for revision and submitted seven recommendations for the 2021 Medicare Physician Payment Schedule.

In 2020, the RUC identified one code with Medicare data from 2017-2019e that was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period and 2019e Medicare utilization over 10,000. The RUC will review this service at its April 2021 meeting.

High Volume Growth

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have increased by at least 100% from 2004 through 2006. The query initially resulted in the identification of 81 services, but was expanded by 16 services to include the family of services, totaling 97 services. Specialty societies submitted comments to the Workgroup in April 2008 to provide rationales for the growth in reporting. Following this review, the RUC required the specialties to survey 35 services to capture the appropriate work effort and/or direct practice expense inputs. These services were reviewed by the RUC between February 2009 and April 2010.

The RUC recommended removing 15 services from the screen as the volume growth did not impact the resources required to provide these services. The CPT® Editorial Panel deleted 34 codes. The RUC submitted 44 recommendations to CMS for services for the 2012-2017 Medicare Physician Payment Schedules and four recommendations for the CPT 2020 Medicare Physician Payment Schedule. The RUC completed review of services under this first iteration of the high growth screen.

In April 2013, the RUC assembled a list of all services with a total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 through 2011. The query resulted in the identification of 40 services and expanded to 62 services to include the appropriate family of services. The RUC recommended removing three services from the screen as the volume growth did not impact the resources required to provide these services. The RUC recommended review of two services after an additional utilization data is collected. The CPT® Editorial Panel deleted ten codes and the RUC submitted recommendations for 47 services for the 2015-2019 Medicare Physician Payment Schedule.

In October 2015, the RUC ran this screen again for services based on Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The query resulted in the identification of 19 services and expanded to 31 services to include the appropriate family of services. The RUC recommended removing one service from the screen as the volume growth did not impact the resources required to provide these services. The RUC will review three services after an additional

utilization data is collected. The CPT Editorial Panel deleted 12 codes and the RUC submitted recommendations for 15 services for the 2017-2020 Medicare Physician Payment Schedules.

In October 2016, the RUC ran this screen for its fourth iteration and the query resulted in the identification of 12 services, which was expanded to 53 services. The RUC recommended removing two services from the screen as the volume growth did not impact the resources required to provide these services. The CPT Editorial Panel deleted five services. The RUC submitted recommendations for 46 services for the 2019-2022 Medicare Physician Payment Schedules. The RUC completed review of services under this fourth iteration of the high volume growth screen.

In October 2018, the RUC ran this query for its fifth iteration for services with 2017e Medicare utilization of 10,000 or more that has increased by at least 100% from 2012 through 2017. Eleven (11) codes were identified. The RUC recommended removing two services from the screen as the volume growth was appropriate. The CPT Editorial Panel deleted one code. The RUC referred one code to the CPT Editorial Panel for revision and submitted recommendations for seven services for the 2020-2021 Medicare Physician Payment Schedule.

In October 2019, the RUC completed its sixth iteration of this screen for services with 2018e Medicare utilization of over 10,000 that have increased by at least 100% from 2013 through 2018. The RUC identified 12 services. The RUC removed three services from the screen as the volume growth did not impact the resources required to provide these services. The RUC will review one code after additional utilization data is available. The RUC submitted recommendations for seven services for the 2021 Medicare Physician Payment Schedule and will review the remaining service for the 2023 Medicare Physician Payment Schedule.

In October 2020, the RUC completed its seventh iteration of this screen for services with 2019e Medicare utilization over 10,000 that have increased by at least 100% from 2014 through 2019. The RUC removed four services as the growth was appropriate, referred one code to CPT for revision and will review the remaining service for the 2023 Medicare Physician Payment Schedule.

CMS Fastest Growing

In 2008, CMS developed the Fastest Growing Screen to identify all services with growth of at least 10% per year over the course of three years from 2005-2007. Through this screen, CMS identified 114 fastest growing services and the RUC added 69 services to include the family of services, totaling 183. The RUC required the specialties to survey 72 services to capture the appropriate work effort and/or direct practice expense inputs. These services were reviewed by the RUC from February 2008 through April 2010 and submitted to CMS for the Medicare Physician Payment Schedule.

The RUC recommended removing 27 services from the screen as the volume growth did not impact the resources required to provide the service. The CPT® Editorial Panel deleted 43 codes. The RUC submitted 41 recommendations to CMS for the 2012-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

High IWPUT

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWPUT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC has reviewed and submitted recommendations to CMS for 28 codes, removing four services from the screen as the IWPUT was considered appropriate. The RUC completed review of services under this screen.

Services Surveyed by One Specialty – Now Performed by a Different Specialty
In October 2009, services that were originally surveyed by one specialty, but now performed predominantly by other specialties were identified and reviewed. The RUC identified 21 services by this screen, adding 19 services to address various families of codes. The majority of these services required clarification within CPT®. The CPT® Editorial Panel deleted 18 codes. The RUC submitted 22 recommendations for physician work and practice expense to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In April 2013, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified and the RUC recommended that one be removed from the screen since the specialty societies currently performing this service indicated that the service is appropriate and recommended that the other code be referred to CPT® to be revised. The RUC completed review of services under this screen.

In October 2019, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified, one was deleted by CPT Editorial Panel and other was referred to develop a CPT Assistant article for education. The RUC completed review of services under this screen

Harvard Valued
Utilization over 1 Million
CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization. The RUC identified nine Harvard valued services with high utilization (performed over 1 million times per year). The RUC also incorporated an additional 12 Harvard valued codes within the initial family of services identified. The CPT® Editorial Panel deleted one code. The RUC submitted 20 relative value work recommendations to CMS for the 2011 and 2012 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 100,000
The RUC continued to review Harvard valued codes with significant utilization. The Relativity Assessment Workgroup expanded the review of Harvard codes to those with utilization over 100,000 which totaled 38 services. The RUC expanded this screen by 101 codes to include the family of services, totaling 139 services. The CPT® Editorial Panel deleted 27 codes. The RUC submitted 112 recommendations to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 30,000
In April 2011, the RUC continued to identify Harvard valued codes with utilization over 30,000, based on 2009 Medicare claims data. The RUC determined that the specialty societies should survey the remaining 36 Harvard codes with utilization over 30,000 for September 2011. The RUC expanded the screen to include the family of services, totaling 65 services. The CPT® Editorial Panel deleted 12 codes. The RUC submitted recommendations for 53 services for the 2013-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In October 2015, the RUC reran this screen on Harvard valued services with 2014e Medicare utilization over 30,000. Seven services were identified and expanded to nine codes to include the family of services. The CPT Editorial Panel deleted two codes. The RUC submitted recommendations for 7 services for the 2018-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In October 2018, the RUC reran this screen on Harvard valued services with 2017e Medicare utilization over 30,000. One service was identified. The RUC submitted this recommendation for the 2021 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

In October 2019, the RUC reran this screen on Harvard valued services with 2018e Medicare utilization over 30,000. Three services were identified, which was expanded to four to include the family of services. The RUC submitted recommendations for 3 services for the 2022 Medicare Physician Payment Schedule and will submit one recommendation for the 2023 Medicare Physician Payment Schedule.

In October 2020, the RUC ran this service on Harvard valued services with 2019e Medicare utilization over 30,000 and one service was identified. The RUC will review this service for the 2023 Medicare Physician Payment Schedule.

Medicare Allowed Charges >$10 million
In June 2012, CMS identified 16 services that were Harvard valued with annual allowed charges (2011 data) > $10 million. The RUC expanded this screen to 33 services to include the proper family of services. The RUC removed two services from review as the allowed charges are approximately $1 million and did not meet the screen criteria. The CPT® Editorial Panel deleted one service. The RUC submitted recommendations for 30 services for the 2013-2017 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS/Other
Utilization over 500,000
In April 2011, the RUC identified 410 codes with a source of "CMS/Other." CMS/Other codes are services which were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS or were part of a radiology fee schedule. "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the RUC recommended that a list of all CMS/Other codes be developed and reviewed. The RUC established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The RUC expanded this screen to 21 services to include the proper family of services. The CPT® Editorial Panel deleted three services. The RUC submitted recommendations for 16 services for the 2013-2015 Medicare Physician Payment Schedules. The RUC removed one service from the screen and will review one code after additional data are available.

Utilization over 250,000
In April 2013, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 250,000 or more, which resulted in 26 services and was expanded to 52 services to include the family of services. The CPT Editorial Panel deleted 11 codes identified under this screen. The RUC removed nine services and submitted 32 recommendations to CMS for the 2015-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 100,000
In October 2016, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 100,000 or more, which resulted in 27 services and was expanded to 41 services to include the family of services. The RUC referred two codes to CPT for deletion and submitted recommendations for 39 services for the 2019 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Utilization over 30,000
In October 2017, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 30,000 or more, which resulted in 34 services and was expanded to 55 services to include the family of services. The CPT Editorial Panel deleted 10 codes. The submitted recommendations for 45 services for the 2019-2020 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In October 2018, the RUC reran this screen for CMS/Other source codes with 2017e Medicare utilization over 30,000, which resulted in seven services and expanded to 15 services. The CPT Editorial Panel deleted one code. The RUC submitted recommendations for 14 services for the 2020-21 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 20,000
In October 2019, the RUC lowered the threshold for this screen of CMS/Other source codes with 2018e Medicare utilization over 20,000, which resulted in nine services and expanded to 15 to include the family of services. The CPT Editorial Panel deleted five codes. The RUC submitted recommendations for three services for the 2021 Medicare Physician Payment Schedule and will review 6 services for the 2022 Medicare Physician Payment Schedule. The RUC will review one service after additional utilization data is available.

In October 2020, the RUC ran a second iteration of this screen of CMS/Other source codes with 2019e Medicare Utilization over 20,000, which resulted in 11 services. Three services were removed from this screen, one was referred to the CPT Editorial Panel for revision and seven will be reviewed after additional utilization data is available.

Bundled CPT® Services
Reported 95% or More Together
The Relativity Assessment Workgroup solicited data from CMS regarding services inherently performed by the same physician on the same date of service (95% of the time) in an attempt to identify pairings of services that should be bundled together. The CPT® Editorial Panel deleted 31 individual component codes and replaced them with 53 new codes that describe bundles of services. The RUC then surveyed and reviewed work and practice costs associated with these services to account for any efficiencies achieved through the bundling. The RUC completed review of all services under this screen.

Reported 75% or More Together
In February 2010, the Workgroup continued review of services provided on the same day by the same provider, this time lowering the threshold to 75% or more together. The Relativity Assessment Workgroup again analyzed the Medicare claims data and found 151 code pairs which met the threshold. The Workgroup then collected these code pairs into similar "groups" to ensure that the entire family of services would be coordinated under one code bundling proposal. The grouping effort resulted in 20 code groups, totaling 80 codes, and were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. Resulting from the Relativity Assessment Workgroup review, 81 additional codes were added for review as part of the family of services to ensure duplication of work and practice expense was mitigated throughout the entire set of services. Of the 161 total codes under review, the CPT® Editorial Panel deleted 35 individual component codes and replaced the component coding with 126 new and/or revised codes that described the bundles of services. The RUC will review one service after additional utilization data is available.

In August 2011, the Joint CPT®/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its third cycle of analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 30 code pair groups and recommended code bundling for 64 individual codes. In October 2012, the CPT® Editorial Panel started the review of code bundling solutions. Of the 153 total codes under review, the CPT® Editorial Panel deleted 50 services. The RUC has submitted 103 code recommendations for the 2014-2019 Medicare Physician Payment Schedules. The RUC completed review of all services under this screen.

In January and April 2015, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its fourth cycle analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 8 code pair groups and recommended code bundling for 18 individual codes. In October 2015, the CPT Editorial Panel started review of the code bundling solutions. Of the 75 total codes under review, the CPT Editorial Panel deleted 26 services. The RUC submitted 47 code recommendations for the 2017-2019 Medicare Physician Payment Schedules and will review the two services after additional utilization data is available.

In October 2017 the Relativity Assessment Workgroup performed the fifth cycle analysis of code pairs reported together with 75% or greater frequency. Only groups that totaled allowed charges of $5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in Medicare claims data and/or contained at least one ZZZ global service were removed. Based on these criteria four groups or 8 codes were identified. The Relativity Assessment Workgroup determined two groups totaling four codes require code bundling solutions. Of the 12 total codes under review, the CPT Editorial Panel deleted one service. The RUC submitted 11 code recommendations for the 2020 and 2021 Medicare Physician Payment Schedules. The RUC completed review of all services under this screen.

Low Value/Billed in Multiple Units
CMS has requested that services with low work RVUs that are commonly billed with multiple units in a single encounter be reviewed. CMS identified services that are reported in multiples of five or more per day, with work RVUs of less than or equal to 0.50 RVUs.

In October 2010, the Workgroup reviewed 12 CMS identified services and determined that six of the codes were improperly identified as the services were either not reported in multiple units or were reported in a few units and that was considered in the original valuation. The RUC submitted recommendations for the remaining six services for the 2012 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Low Value/High Volume Codes
CMS has requested that services with low work RVUs and high utilization be reviewed. CMS has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization. The RUC questioned the criteria CMS used to identify these services as it appeared some codes were missing from the screen criteria indicated. The RUC identified codes with a work RVU ranging from 0.01 - 0.50 and Medicare utilization greater than one million. In February 2011, the RUC reviewed the codes identified by this criteria and added 5 codes, totaling 29. The RUC submitted 24 recommendations to CMS for the 2012 Medicare Physician Payment Schedule and five recommendations to CMS for the 2013 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Multi-Specialty Points of Comparison List
CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data as well as those services reviewed by the RUC more than six years ago. The RUC expanded the list to 182 services to include additional codes as part of a family (over 100 of these codes are part of the review of GI endoscopy codes). The CPT® Editorial Panel deleted 25 codes. The RUC submitted recommendations for 157 codes for the 2012-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS High Expenditure Procedural Codes
In the Proposed Rule for 2012, CMS requested that the RUC review a list of 70 high Medicare Physician Payment Schedule expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes since they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

The RUC reviewed the 70 services identified and expanded the list to 145 services to include additional codes as part of the family. The CPT® Editorial Panel deleted 20 codes. The RUC submitted 125 recommendations to CMS for the 2013-2019 Medicare Physician Payment Schedules. The RUC completed review of services under the first iteration of this screen.

In the Final Rule for 2016, CMS requested that the RUC review a list of 103 high Medicare Physician Payment Schedule high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

The RUC expanded the list of services to 238 services to include additional codes as part of the family. The CPT Editorial Panel deleted 30 codes. The RUC submitted 208 recommendations to CMS for the 2017-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Services with Stand-Alone PE Procedure Time
In June 2012, CMS proposed adjustments to services with stand-alone procedure time assumptions used in developing non-facility PE RVUs. These assumptions are not based on physician time assumptions. CMS prioritized CPT® codes that have annual Medicare allowed charges of $100,000 or more, include direct equipment inputs that amount to $100 or more, and have PE procedure times greater than five minutes for review. The RUC reviewed 27 services identified through this screen and expanded to 29 services to include additional codes as part of the family. The CPT® Editorial Panel deleted 11 codes. The RUC submitted 18 recommendations for the 2014-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Pre-Time Analysis
In January 2014, the RUC reviewed codes that were RUC reviewed prior to April 2008, with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 19 services with more pre-service time than the longest standardized pre-service package and was expanded to 24 to include additional codes as part of the family. The RUC reviewed these services and referred three services to the CPT® Editorial Panel for revision. The CPT Editorial Panel deleted one service and will review three services for CPT 2018. The RUC reviewed 18 services and noted that they were all originally valued by magnitude estimation and therefore readjustments in pre-service time categories did not alter the work values. Additionally, crosswalk references for each service were presented validating the pre-time adjustments.

The RUC noted that this screen was useful, however did not reveal any large outliers and therefore the utilization threshold does not need to be lowered to identify more services. The RUC submitted 20 recommendations for the 2016 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Post-Operative Visits

010-Day Global Codes

In January 2014, the RUC reviewed all 477, 010-day global codes to determine any outliers. Many 010-day global period services only include one post-operative office visit. The Relativity Assessment Workgroup pared down the list to 19 services with >1.5 office visits and 2012 Medicare utilization > 1,000. The RUC reviewed the 19 services, which was expanded to 21 services for additional codes in the family of services, identified via this screen. The RUC referred two codes to the CPT Editorial Panel for revision. The RUC submitted recommendations for 21 services for the 2015-2017 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

In October 2019, the identified five 010-day global period services more than one office visit based on 2018e Medicare utilization over 1,000, which was expanded to eight services to include the family of services. The RUC submitted eight recommendations for the 2021-2022 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

090-Day Global Codes

In January 2014, the RUC reviewed all 3,788, 090-day global codes to determine any outliers. Based on 2012 Medicare utilization data, 10 services were identified, that were reported at least 1,000 times per year and included more than six office visits. The RUC expanded the services identified in this screen to 38 to include additional codes as part of the family. The CPT® Editorial Panel deleted 8 services. The RUC submitted recommendations for 30 services for the 2015-2017 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

In October 2019, the identified three 090-day global period services more than six office visits based on 2018e Medicare utilization over 1,000. The RUC submitted recommendations for these three services for the 2021 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

High Level E/M in Global Period

In October 2015, the RUC reviewed all services with Medicare utilization greater than 10,000 that have a level 4 (99214) or level 5 (99215) office visit included in the global period. There were no codes with volume greater than 10,000 that had a level 5 office visits included. Seven services were identified that have a level 4 office visit included. The RUC expanded the list of services to 11 services to include additional codes as part of the family. The RUC confirmed that the level 4 post-operative visits were appropriate and well-defined for four services. The CPT Editorial Panel deleted one code. The RUC submitted recommendations for 10 services for the 2017-2018 Medicare Physician Payment Schedules. The RUC noted that this screen will be complete after these services are reviewed because the RUC has more rigorously questioned level 4 office visits in the global period in recent years and will continue this process going forward. The RUC has completed review of the services under this screen.

000-Day Global Services Reported with an E/M with Modifier 25

In the NPRM for 2017 CMS identified 83 services with a 000-day global period billed with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000.

The RUC commented that it appreciated CMS' identification of an objective screen and reasonable query. However, based on further analysis of the codes identified, it appears only 19 services met the criteria for this screen and have not been reviewed to specifically address an E/M performed on the same date. There were 38 codes that did not meet the screen criteria; they were either reviewed in the last 5 years and/or are not typically reported with an E/M. For 26 codes, the summary of recommendation (SOR), RUC rationale or practice expense inputs submitted specifically states that an E/M is typically reported with these services and the RUC accounted for this in its valuation.

The RUC requested that CMS remove 64 services that did not meet the screen criteria or which have already been valued as typically being reported with an E/M service. The RUC requested that CMS condense and finalize the list of services for this screen to the 19 remaining services.

In the Final Rule for 2017, CMS did finalize the list of 000-day global services reported with an E/M to the 19 services that truly met the criteria. The RUC recommended that two additional codes be removed from this screen as the specialty societies discovered that in fact an E/M as typical was considered in the survey process. Additional codes were added as part of the family of codes identified, totaling 22. The CPT Editorial Panel deleted one code and the RUC submitted 21 recommendations for the 2019 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Negative IWPUT
In October 2017, the RUC identified 22 services with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. The RUC expanded the services identified in this screen to 56 services to include additional codes as part of the family. The CPT Editorial Panel deleted 15 services. The RUC submitted 41 recommendations for the 2019-2020 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Contractor Priced with High Volume
In April 2018, the RUC identified five contractor-priced Category I CPT codes that have 2017 estimated Medicare utilization over 10,000. The RUC expanded the services identified in this screen to seven to include additional codes as part of a family. The CPT Editorial Panel deleted two codes. The RUC submitted four recommendations for the 2020-2021 Medicare Physician Payment Schedule. The RUC will review the remaining service after two years of additional data is available.

CPT Modifier -51 Exempt List
In April 2018, the RUC identified seven services on the CPT Modifier -51 *Multiple Procedures* exempt list with 2017 estimated Medicare utilization over 10,000. The RUC examined the data provided on the percentage reported alone, physician pre and intra time and determined that this is an appropriate screen. The RUC recommended that four services be removed from the Modifier -51 exempt list and that three services remain on the list as they are separate and distinct services. The RUC notes that the CPT Editorial Panel will be reexamining this list in February 2019. The RUC has completed review of the services under this screen.

PE Units Screen
In April 2020, the RUC identified seven services with more than one median unit of service reported and a direct practice expense supply item unit cost greater than $100 based on 2018 Medicare utilization. In October 2020, the Practice Expense Subcommittee reviewed the supplies and kits identified to determine if any duplication occurs when reported in multiple units. The RUC determined that three of the seven codes identified had duplicative supplies. The RUC submitted new direct practice expense inputs for the 2022 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Public Comment Requests
In 2011, CMS announced that due to the ongoing identification of potentially misvalued services by CMS and the RUC, the Agency will no longer conduct a separate Five-Year Review. CMS will now call for public comments on an annual basis as part of the comment process on the Final Rule each year.

Final Rule for 2013
In the Final Rule for the 2013 Medicare Physician Payment Schedule, the public and CMS identified 35 potentially misvalued services, which was expanded to 39 services to include the entire code family. The RUC reviewed these services and recommended that eight services be removed from review as two G-codes lacked specialty society interest and six services are not potentially misvalued since there is no reliable way to determine an incremental difference from open thoracotomy to thorascopic procedures. The CPT Editorial Panel deleted two services. The RUC submitted recommendations for 29 services for the 2014-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2014
CMS did not receive any publicly nominated potentially misvalued codes for inclusion in the Proposed Rule for 2014. To broaden participation in the process of identifying potentially misvalued codes, CMS sought the input of Medicare contractor medical directors (CMDs). The CMDs have identified over a dozen services which CMS is proposing as potentially misvalued. The RUC reviewed these services and appropriate families, totaling 90 services. The CPT® Editorial Panel deleted 11 services. The RUC submitted recommendations to CMS for 79 services for the 2015-2018 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2015
In the Final Rule for 2015 the public and CMS nominated 26 services as potentially misvalued, which the RUC expanded to 53 services to include additional codes as part of this family. The CPT Editorial Panel deleted 16 services. The RUC submitted 37 recommendations for the 2016-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2016
In the Final Rule for 2016 the public and CMS nominated 25 services as potentially misvalued, which the RUC expanded to 53 services to include an additional code as part of the family. The CPT Editorial Panel deleted eight services. The RUC submitted 45 recommendations for the 2017-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2017
In the Final Rule for 2017 there were no public nominations for services in which the RUC was not already addressing.

Final Rule for 2018
In the Final Rule for 2018 the public and CMS nominated six services as potentially misvalued, which the RUC expanded to nine services. The RUC submitted nine recommendations for the 2019-2020 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2019
In the Final Rule for 2019 the public and CMS nominated nine services as potentially misvalued, which was expanded to 12 services as part of the family. The CPT Editorial Panel deleted two services. The RUC will submit 10 recommendations for the 2021 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Final Rule for 2020
In the Final Rule for 2020, the public and CMS nominated 10 services as potentially misvalued. The RUC referred six services to the CPT Editorial Panel and submitted recommendations for 3 services for the 2021 Medicare Physician Payment Schedule. The RUC could not submit a recommendation for one code as it was determined it was not adequately described to evaluate.

Final Rule for 2021
In the Final Rule for 2021, CMS received public nomination of one code as potentially misvalued. The RUC will review this service at the January 2021 RUC meeting. The RUC submitted the recommendation for the 2022 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Work Neutrality
For every CPT code recommendation and family, the RUC submits utilization assumptions based on the specialty societies estimate for the next year of Medicare utilization. Starting with CPT 2009, the Relativity Assessment Workgroup began assessing all services for work neutrality. In 2012, the RUC confirmed that the RUC and specialty societies work neutrality calculation expectation is a zero change target. However, if actual work RVUs turn out to be 10% or greater than the former work RVUs for the family, the family should undergo review by the Relativity Assessment Workgroup. Three code families have been identified for re-examination, one from CPT 2009, CPT 2011 and CPT 2012. Two families were determined to have correct utilization assumptions after re-evaluating the coding structure and initial assumptions. The CPT 2012 family went through revisions at the CPT Editorial Panel as well as extensive educational efforts were engaged. However, after continued examination this family will be resurveyed for the 2022 Medicare Physician Payment Schedule.

Three additional code families were identified for re-examination from CPT 2018. One family appears to possibly be due to miscoding. All three families will be re-examined after additional utilization data are available.

Other Issues
In addition to the above screening criteria, the Relativity Assessment Workgroup performed an exhaustive search of the RUC database for services indicated by the RUC to be re-reviewed at a later date. Three codes were found that had not yet been re-reviewed. The RUC recommended a work RVU decrease for two codes and to maintain the work RVU for another code. CMS also identified 72 services that required further practice expense review. The RUC submitted practice expense recommendations on 67 services and the CPT® Editorial Panel deleted 5 services. The RUC also reviewed special requests for 19 audiology and speech-language pathology services. The RUC submitted recommendations for 10 services for the 2010 Medicare Physician Payment Schedule and the remaining nine services for the 2011 Medicare Physician Payment Schedule.

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	**2,586**
Codes Completed	**2,509**
Work and PE Maintained	669
Work Increased	313
Work Decreased	868
Direct Practice Expense Revised (beyond work changes)	182
Deleted from CPT®	472
Codes Under Review	**77**
Referred to CPT® Editorial Panel or CPT Assistant	38
RUC to Review for *CPT 2022*	8
RUC to review future review after additional data obtained	31

**The total number of codes identified will not equal the number of codes from each screen as some codes have been identified in more than one screen.*

The RUC's efforts for 2009-2021 have resulted in more than $5 billion in annual redistribution within the Medicare Physician Payment Schedule.

Status Report: CMS Requests and Relativity Assessment Issues

Global: **Issue:** **Screen:** **Complete?** No

Most Recent RUC Meeting: **Tab:** **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

00534 **Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ASA **First Identified:** October 2018 **2019 est Medicare Utilization:** 30,245

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

00537 **Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation**

Global: XXX **Issue:** Anesthesia for Cardiac Electrophysiologic Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 13 **Specialty Developing Recommendation:** ASA **First Identified:** October 2016 **2019 est Medicare Utilization:** 89,969

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 12 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

00560 **Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ASA **First Identified:** October 2018 **2019 est Medicare Utilization:** 58,933

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

00731 **Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA

First Identified: September 2016

2019 est Medicare Utilization: 1,262,160

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5 base units

Referred to CPT September 2016

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

00732 **Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA

First Identified: September 2016

2019 est Medicare Utilization: 105,226

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 6 base units

Referred to CPT September 2016

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA

First Identified: July 2015

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

00810 **Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum**

Global: **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

00811 **Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,186,122

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 4 base units **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

00812 **Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** September 2016 **2019 est Medicare Utilization:** 517,650

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 3 base units **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

00813 **Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum**

Global: XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** September 2016 **2019 est Medicare Utilization:** 492,977

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5 base units **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

00918 **Anesthesia for transurethral procedures (including urethrocystoscopy); with fragmentation, manipulation and/or removal of ureteral calculus**

Global: XXX **Issue:** Anesthesia for transurethral procedures **Screen:** High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

01916 **Anesthesia for diagnostic arteriography/venography**

Global: XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 58,939

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

0191T **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion**

Global: XXX **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** October 2019 **2019 est Medicare Utilization:** 57,829

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

01930 **Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified**

Global: XXX **Issue:** Anesthesia for Interventional Radiology **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 17,980

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

01935 **Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic**

Global: XXX **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

01936 **Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic**

Global: XXX **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** October 2016 **2019 est Medicare Utilization:** 311,884

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX2

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 4 **Referred to CPT** October 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

01XX3

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 4 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX4

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 4 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX5

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 4 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

01XX6

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 6 **Referred to CPT** October 2020 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

01XX7

Global: **Issue:** Anesthesia Services for Image-Guided Spinal Procedures **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 04 **Specialty Developing Recommendation:** ASA **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 6 **Referred to CPT** October 2020 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

0275T **Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar**

Global: YYY **Issue:** **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 2,656

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

0376T **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** October 2019 **2019 est Medicare Utilization:** 16,708

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

0379T **Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional**

Global: XXX **Issue:** **Screen:** High Volume Category III Codes **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 49,050

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review in 3 years (Oct 2023) **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

0394T **High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed**

Global: XXX **Issue:** **Screen:** High Volume Category III Codes **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 28,857

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review in 3 years (Oct 2023) **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

0446T **Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training**

Global: YYY **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 33 **Specialty Developing Recommendation:** AACE, ES

First Identified: November 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.14
2021 NF PE RVU: 53.70
2021 Fac PE RVU: 0.44

RUC Recommendation: Refer to CPT time uncertain **Referred to CPT** February 2021 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

0447T **Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision**

Global: YYY **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 33 **Specialty Developing Recommendation:** AACE, ES

First Identified: November 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.34
2021 NF PE RVU: 1.55
2021 Fac PE RVU: 0.52

RUC Recommendation: Refer to CPT time uncertain **Referred to CPT** February 2021 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

0448T **Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation**

Global: YYY **Issue:** Insertion/ Removal of Implantable Interstital Glucose Sensor System **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 33 **Specialty Developing Recommendation:** AACE, ES

First Identified: November 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.91
2021 NF PE RVU: 53.16
2021 Fac PE RVU: 0.74

RUC Recommendation: Refer to CPT time uncertain **Referred to CPT** February 2021 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

0449T **Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device**

Global: YYY **Issue:** **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:**

First Identified: October 2019

2019 est Medicare Utilization: 5,679

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

0474T **Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space**

Global: XXX **Issue:** **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:**

First Identified: October 2019

2019 est Medicare Utilization: 12

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

0509T **Electroretinography (ERG) with interpretation and report, pattern (PERG)**

Global: XXX **Issue:** Electroretinography **Screen:** Work Neutrality 2019 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization:

2021 Work RVU: 0.40
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

0X12T

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO

First Identified: January 2021

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Contractor Price

Referred to CPT October 2020
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Contractor Price

Status Report: CMS Requests and Relativity Assessment Issues

10004 **Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017

2019 est Medicare Utilization: 503

2021 Work RVU: 0.80
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

10005 **Fine needle aspiration biopsy, including ultrasound guidance; first lesion**

Global: XXX **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 / CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: June 2017

2019 est Medicare Utilization: 145,323

2021 Work RVU: 1.46
2021 NF PE RVU: 2.38
2021 Fac PE RVU: 0.50

RUC Recommendation: 1.63

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

10006 **Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017

2019 est Medicare Utilization: 33,658

2021 Work RVU: 1.00
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

10007 **Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion** **Global:** XXX **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** June 2017 **2019 est Medicare Utilization:** 395

2021 Work RVU: 1.81
2021 NF PE RVU: 7.06
2021 Fac PE RVU: 0.67

RUC Recommendation: 1.81 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

10008 **Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** June 2017 **2019 est Medicare Utilization:** 32

2021 Work RVU: 1.18
2021 NF PE RVU: 3.52
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

10009 **Fine needle aspiration biopsy, including CT guidance; first lesion** **Global:** XXX **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** June 2017 **2019 est Medicare Utilization:** 5,300

2021 Work RVU: 2.26
2021 NF PE RVU: 11.44
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.43 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10010 **Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017 **2019 est Medicare Utilization:** 99

2021 Work RVU: 1.65
2021 NF PE RVU: 6.42
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

10011 **Fine needle aspiration biopsy, including MR guidance; first lesion**

Global: XXX **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017 **2019 est Medicare Utilization:** 69

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Contractor Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

10012 **Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fine Needle Aspiration **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 04 **Specialty Developing Recommendation:**

First Identified: June 2017 **2019 est Medicare Utilization:** 21

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Contractor Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10021 **Fine needle aspiration biopsy, without imaging guidance; first lesion**

Global: XXX **Issue:** Fine Needle Aspiration **Screen:** CMS Request - Final Rule for 2016 / CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 21 **Specialty Developing Recommendation:** AACE, ASBS, ASC, CAP, ES, AAOHNS, ACS **First Identified:** July 2015 **2019 est Medicare Utilization:** 17,957

2021 Work RVU: 1.03
2021 NF PE RVU: 1.85
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.20 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

10022 **Fine needle aspiration; with imaging guidance**

Global: **Issue:** Fine Needle Aspiration **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 04 **Specialty Developing Recommendation:** AACE, ASBS, ASC, CAP, ES, ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

10030 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 8,525

2021 Work RVU: 2.75
2021 NF PE RVU: 16.52
2021 Fac PE RVU: 0.94

RUC Recommendation: 3.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10040 **Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)**

Global: 010 **Issue:** Acne Surgery **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 13 **Specialty Developing Recommendation:** AAD **First Identified:** October 2015 **2019 est Medicare Utilization:** 41,492

2021 Work RVU: 0.91
2021 NF PE RVU: 2.42
2021 Fac PE RVU: 0.52

RUC Recommendation: 0.91 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

10060 **Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single**

Global: 010 **Issue:** Incision and Drainage of Abscess **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 368,976

2021 Work RVU: 1.22
2021 NF PE RVU: 2.27
2021 Fac PE RVU: 1.66

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

10061 **Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple**

Global: 010 **Issue:** Incision and Drainage of Abscess **Screen:** Harvard Valued - Utilization over 100,000 / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** APMA **First Identified:** October 2009 **2019 est Medicare Utilization:** 134,001

2021 Work RVU: 2.45
2021 NF PE RVU: 3.45
2021 Fac PE RVU: 2.57

RUC Recommendation: Maintain. 2.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10120 **Incision and removal of foreign body, subcutaneous tissues; simple** **Global:** 010 **Issue:** **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 12 **Specialty Developing Recommendation:** APMA, AAFP **First Identified:** April 2011 **2019 est Medicare Utilization:** 43,240

2021 Work RVU: 1.22
2021 NF PE RVU: 3.14
2021 Fac PE RVU: 1.68

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

10180 **Incision and drainage, complex, postoperative wound infection** **Global:** 010 **Issue:** **Screen:** RUC identified when reviewing comparison codes **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** January 2013 **2019 est Medicare Utilization:** 9,692

2021 Work RVU: 2.30
2021 NF PE RVU: 4.99
2021 Fac PE RVU: 2.44

RUC Recommendation: Remove from re-review **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11040 **Deleted from CPT** **Global:** **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

11041 **Deleted from CPT** **Global:** **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11042 **Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,938,307

2021 Work RVU: 1.01
2021 NF PE RVU: 2.68
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.12 **Referred to CPT** October 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11043 **Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:** 456,527

2021 Work RVU: 2.70
2021 NF PE RVU: 3.78
2021 Fac PE RVU: 1.40

RUC Recommendation: 3.00 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11044 **Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less**

Global: 000 **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** APMA, APTA **First Identified:** September 2007 **2019 est Medicare Utilization:** 88,567

2021 Work RVU: 4.10
2021 NF PE RVU: 4.42
2021 Fac PE RVU: 1.83

RUC Recommendation: 4.56 **Referred to CPT** October 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

11045 **Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 492,140

2021 Work RVU: 0.50
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11046 **Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 239,254

2021 Work RVU: 1.03
2021 NF PE RVU: 0.94
2021 Fac PE RVU: 0.40

RUC Recommendation: 1.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11047 **Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** ACS, APMA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 66,673

2021 Work RVU: 1.80
2021 NF PE RVU: 1.44
2021 Fac PE RVU: 0.71

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11055 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion**

Global: 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** APMA **First Identified:** November 2011 **2019 est Medicare Utilization:** 886,591

2021 Work RVU: 0.35
2021 NF PE RVU: 1.66
2021 Fac PE RVU: 0.08

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11056 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions**

Global: 000 **Issue:** Trim Skin Lesions **Screen:** MPC List / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 53 **Specialty Developing Recommendation:** APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,010,288

2021 Work RVU: 0.50
2021 NF PE RVU: 1.81
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11057 **Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions**

Global: 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** APMA **First Identified:** November 2011 **2019 est Medicare Utilization:** 346,586

2021 Work RVU: 0.65
2021 NF PE RVU: 1.88
2021 Fac PE RVU: 0.14

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

11100 **Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion**

Global: **Issue:** Biopsy of Skin Lesion **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11101 **Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)**

Global: **Issue:** Biopsy of Skin Lesion **Screen:** Low Value Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

11102 **Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion**

Global: 000 **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:** **First Identified:** February 2017 **2019 est Medicare Utilization:** 3,333,585

2021 Work RVU: 0.66
2021 NF PE RVU: 2.34
2021 Fac PE RVU: 0.38

RUC Recommendation: 0.66 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11103 **Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:** **First Identified:** February 2017 **2019 est Medicare Utilization:** 1,456,282

2021 Work RVU: 0.38
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.22

RUC Recommendation: 0.38 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11104 **Punch biopsy of skin (including simple closure, when performed); single lesion** **Global:** 000 **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:**

First Identified: February 2017 **2019 est Medicare Utilization:** 388,339

2021 Work RVU: 0.83
2021 NF PE RVU: 2.90
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.83 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11105 **Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:**

First Identified: February 2017 **2019 est Medicare Utilization:** 97,094

2021 Work RVU: 0.45
2021 NF PE RVU: 1.29
2021 Fac PE RVU: 0.25

RUC Recommendation: 0.45 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11106 **Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion** **Global:** 000 **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:**

First Identified: February 2017 **2019 est Medicare Utilization:** 37,327

2021 Work RVU: 1.01
2021 NF PE RVU: 3.55
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.01 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11107 **Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Skin Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 05 **Specialty Developing Recommendation:**

First Identified: February 2017 **2019 est Medicare Utilization:** 7,020

2021 Work RVU: 0.54
2021 NF PE RVU: 1.55
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.54 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11300 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD

First Identified: January 2012 **2019 est Medicare Utilization:** 104,786

2021 Work RVU: 0.60
2021 NF PE RVU: 2.38
2021 Fac PE RVU: 0.33

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11301 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD

First Identified: January 2012 **2019 est Medicare Utilization:** 205,570

2021 Work RVU: 0.90
2021 NF PE RVU: 2.67
2021 Fac PE RVU: 0.50

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11302 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 114,770

2021 Work RVU: 1.05
2021 NF PE RVU: 3.02
2021 Fac PE RVU: 0.59

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11303 **Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 16,712

2021 Work RVU: 1.25
2021 NF PE RVU: 3.22
2021 Fac PE RVU: 0.69

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11305 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 100,773

2021 Work RVU: 0.80
2021 NF PE RVU: 2.32
2021 Fac PE RVU: 0.24

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11306 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 102,882

2021 Work RVU: 0.96
2021 NF PE RVU: 2.63
2021 Fac PE RVU: 0.39

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11307 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 51,111

2021 Work RVU: 1.20
2021 NF PE RVU: 2.95
2021 Fac PE RVU: 0.54

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11308 **Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 14,010

2021 Work RVU: 1.46
2021 NF PE RVU: 2.93
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11310 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 74,188

2021 Work RVU: 0.80
2021 NF PE RVU: 2.60
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.19 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

11311 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 100,460

2021 Work RVU: 1.10
2021 NF PE RVU: 2.89
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.43 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11312 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD

First Identified: January 2012

2019 est Medicare Utilization: 46,378

2021 Work RVU: 1.30
2021 NF PE RVU: 3.26
2021 Fac PE RVU: 0.73

RUC Recommendation: 1.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

11313 **Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm**

Global: 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 38 **Specialty Developing Recommendation:** AAD

First Identified: January 2012

2019 est Medicare Utilization: 8,180

2021 Work RVU: 1.68
2021 NF PE RVU: 3.60
2021 Fac PE RVU: 0.94

RUC Recommendation: 2.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

11719 **Trimming of nondystrophic nails, any number**

Global: 000 **Issue:** Debridement of Nail **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 32 **Specialty Developing Recommendation:** APMA

First Identified: October 2010

2019 est Medicare Utilization: 837,707

2021 Work RVU: 0.17
2021 NF PE RVU: 0.23
2021 Fac PE RVU: 0.04

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

11720 **Debridement of nail(s) by any method(s); 1 to 5**

Global: 000 **Issue:** Debridement of Nail **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 53 **Specialty Developing Recommendation:** APMA

First Identified: Septemer 2011

2019 est Medicare Utilization: 2,111,275

2021 Work RVU: 0.32
2021 NF PE RVU: 0.61
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.32 (Interim)

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

11721 **Debridement of nail(s) by any method(s); 6 or more**

Global: 000 **Issue:** Debridement of Nail **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 53 **Specialty Developing Recommendation:** APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 6,784,854

2021 Work RVU: 0.54
2021 NF PE RVU: 0.72
2021 Fac PE RVU: 0.12

RUC Recommendation: 0.54 (Interim) **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11730 **Avulsion of nail plate, partial or complete, simple; single**

Global: 000 **Issue:** Removal of Nail Plate **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 56 **Specialty Developing Recommendation:** APMA **First Identified:** July 2015 **2019 est Medicare Utilization:** 378,522

2021 Work RVU: 1.05
2021 NF PE RVU: 2.29
2021 Fac PE RVU: 0.43

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11750 **Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal**

Global: 010 **Issue:** Excision of Nail Bed - HCPAC **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 201,719

2021 Work RVU: 1.58
2021 NF PE RVU: 3.06
2021 Fac PE RVU: 1.25

RUC Recommendation: 1.99 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11752 **Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx**

Global: **Issue:** Excision of Nail Bed - HCPAC **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11755 **Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)**

Global: 000 **Issue:** Biopsy of Nail **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41i **Specialty Developing Recommendation:** APMA **First Identified:** July 2016 **2019 est Medicare Utilization:** 62,237

2021 Work RVU: 1.25
2021 NF PE RVU: 2.38
2021 Fac PE RVU: 0.43

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

11900 **Injection, intralesional; up to and including 7 lesions**

Global: 000 **Issue:** Skin Injection Services **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAD **First Identified:** October 2009 **2019 est Medicare Utilization:** 265,694

2021 Work RVU: 0.52
2021 NF PE RVU: 1.08
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

11901 **Injection, intralesional; more than 7 lesions**

Global: 000 **Issue:** Skin Injection Services **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAD **First Identified:** February 2010 **2019 est Medicare Utilization:** 73,970

2021 Work RVU: 0.80
2021 NF PE RVU: 1.17
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11980 **Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)**

Global: 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth2 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA **First Identified:** April 2013 **2019 est Medicare Utilization:** 33,888

2021 Work RVU: 1.10
2021 NF PE RVU: 1.54
2021 Fac PE RVU: 0.39

RUC Recommendation: 1.10 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11981 **Insertion, non-biodegradable drug delivery implant**

Global: 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth1 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA **First Identified:** June 2008 **2019 est Medicare Utilization:** 13,060

2021 Work RVU: 1.14
2021 NF PE RVU: 1.70
2021 Fac PE RVU: 0.52

RUC Recommendation: 1.30 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

11982 **Removal, non-biodegradable drug delivery implant**

Global: 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth1 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,500

2021 Work RVU: 1.34
2021 NF PE RVU: 1.85
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.70 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11983 **Removal with reinsertion, non-biodegradable drug delivery implant**

Global: 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA **First Identified:** June 2008 **2019 est Medicare Utilization:** 2,345

2021 Work RVU: 1.91
2021 NF PE RVU: 2.03
2021 Fac PE RVU: 0.81

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12001 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 184,284

2021 Work RVU: 0.84
2021 NF PE RVU: 1.77
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12002 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 142,967

2021 Work RVU: 1.14
2021 NF PE RVU: 1.99
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.14 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12004 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 22,345

2021 Work RVU: 1.44
2021 NF PE RVU: 2.18
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.44 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12005 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 6,059

2021 Work RVU: 1.97
2021 NF PE RVU: 2.84
2021 Fac PE RVU: 0.46

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12006 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 1,137

2021 Work RVU: 2.39
2021 NF PE RVU: 3.22
2021 Fac PE RVU: 0.59

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12007 **Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 357

2021 Work RVU: 2.90
2021 NF PE RVU: 3.42
2021 Fac PE RVU: 0.81

RUC Recommendation: 2.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12011 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 90,553

2021 Work RVU: 1.07
2021 NF PE RVU: 2.06
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.07 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12013 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 50,435

2021 Work RVU: 1.22
2021 NF PE RVU: 2.02
2021 Fac PE RVU: 0.26

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12014 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 6,842

2021 Work RVU: 1.57
2021 NF PE RVU: 2.37
2021 Fac PE RVU: 0.33

RUC Recommendation: 1.57 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12015 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 3,321

2021 Work RVU: 1.98
2021 NF PE RVU: 2.74
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.98 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12016 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 526

2021 Work RVU: 2.68
2021 NF PE RVU: 3.30
2021 Fac PE RVU: 0.59

RUC Recommendation: 2.68 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12017 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 72

2021 Work RVU: 3.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.67

RUC Recommendation: 3.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12018 **Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm**

Global: 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 32 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** April 2010 **2019 est Medicare Utilization:** 17

2021 Work RVU: 3.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.74

RUC Recommendation: 3.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

12031 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 63,049

2021 Work RVU: 2.00
2021 NF PE RVU: 5.54
2021 Fac PE RVU: 2.15

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12032 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** October 2009 **2019 est Medicare Utilization:** 280,457

2021 Work RVU: 2.52
2021 NF PE RVU: 6.28
2021 Fac PE RVU: 2.71

RUC Recommendation: 2.52 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12034 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 25,707

2021 Work RVU: 2.97
2021 NF PE RVU: 6.53
2021 Fac PE RVU: 2.60

RUC Recommendation: 2.97 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12035 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,889

2021 Work RVU: 3.50
2021 NF PE RVU: 7.58
2021 Fac PE RVU: 2.92

RUC Recommendation: 3.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12036 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,073

2021 Work RVU: 4.23
2021 NF PE RVU: 7.86
2021 Fac PE RVU: 3.22

RUC Recommendation: 4.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

12037 **Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 458

2021 Work RVU: 5.00
2021 NF PE RVU: 8.45
2021 Fac PE RVU: 3.61

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

12041 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 20,831

2021 Work RVU: 2.10
2021 NF PE RVU: 5.46
2021 Fac PE RVU: 1.86

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12042 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 52,449

2021 Work RVU: 2.79
2021 NF PE RVU: 6.05
2021 Fac PE RVU: 2.58

RUC Recommendation: 2.79 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12044 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,304

2021 Work RVU: 3.19
2021 NF PE RVU: 7.68
2021 Fac PE RVU: 2.57

RUC Recommendation: 3.19 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12045 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm** **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 337

2021 Work RVU: 3.75
2021 NF PE RVU: 7.69
2021 Fac PE RVU: 3.48

RUC Recommendation: 3.90 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12046 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 89

2021 Work RVU: 4.30
2021 NF PE RVU: 9.67
2021 Fac PE RVU: 3.99

RUC Recommendation: 4.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12047 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 50

2021 Work RVU: 4.95
2021 NF PE RVU: 10.26
2021 Fac PE RVU: 4.23

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12051 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 54,376

2021 Work RVU: 2.33
2021 NF PE RVU: 5.76
2021 Fac PE RVU: 2.29

RUC Recommendation: 2.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12052 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 75,683

2021 Work RVU: 2.87
2021 NF PE RVU: 6.10
2021 Fac PE RVU: 2.58

RUC Recommendation: Remove from screen **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Remove from Screen

---

12053 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,218

2021 Work RVU: 3.17
2021 NF PE RVU: 7.28
2021 Fac PE RVU: 2.66

RUC Recommendation: 3.17 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

---

12054 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,576

2021 Work RVU: 3.50
2021 NF PE RVU: 7.45
2021 Fac PE RVU: 2.32

RUC Recommendation: 3.50 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

---

Status Report: CMS Requests and Relativity Assessment Issues

12055 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 281

2021 Work RVU: 4.50
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 3.43

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12056 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 41

2021 Work RVU: 5.30
2021 NF PE RVU: 11.05
2021 Fac PE RVU: 5.03

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12057 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm**

Global: 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 25

2021 Work RVU: 6.00
2021 NF PE RVU: 11.25
2021 Fac PE RVU: 5.28

RUC Recommendation: 6.28 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13100 **Repair, complex, trunk; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 6,433

2021 Work RVU: 3.00
2021 NF PE RVU: 6.88
2021 Fac PE RVU: 2.49

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13101 **Repair, complex, trunk; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 102,897

2021 Work RVU: 3.50
2021 NF PE RVU: 8.05
2021 Fac PE RVU: 3.38

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

13102 **Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 26,791

2021 Work RVU: 1.24
2021 NF PE RVU: 2.09
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

13120 **Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,693

2021 Work RVU: 3.23
2021 NF PE RVU: 7.04
2021 Fac PE RVU: 3.22

RUC Recommendation: 3.23 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

Status Report: CMS Requests and Relativity Assessment Issues

13121 **Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 207,941

2021 Work RVU: 4.00
2021 NF PE RVU: 8.34
2021 Fac PE RVU: 3.08

RUC Recommendation: 4.00 **Referred to CPT** September 2018 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

13122 **Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 31,342

2021 Work RVU: 1.44
2021 NF PE RVU: 2.18
2021 Fac PE RVU: 0.78

RUC Recommendation: 1.44 **Referred to CPT** September 2018 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

13131 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 41,454

2021 Work RVU: 3.73
2021 NF PE RVU: 7.46
2021 Fac PE RVU: 2.90

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13132 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 309,273

2021 Work RVU: 4.78
2021 NF PE RVU: 8.81
2021 Fac PE RVU: 3.52

RUC Recommendation: 4.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

13133 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 17,262

2021 Work RVU: 2.19
2021 NF PE RVU: 2.58
2021 Fac PE RVU: 1.22

RUC Recommendation: 2.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

13150 **Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less**

Global: **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

13151 **Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 33,842

2021 Work RVU: 4.34
2021 NF PE RVU: 7.79
2021 Fac PE RVU: 3.26

RUC Recommendation: 4.34 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13152 **Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued with Annual Allowed Charges over $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 54,926

2021 Work RVU: 5.34
2021 NF PE RVU: 8.93
2021 Fac PE RVU: 3.83

RUC Recommendation: 5.34 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

13153 **Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 938

2021 Work RVU: 2.38
2021 NF PE RVU: 2.80
2021 Fac PE RVU: 1.28

RUC Recommendation: 2.38 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

14000 **Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** April 2008 **2019 est Medicare Utilization:** 7,303

2021 Work RVU: 6.37
2021 NF PE RVU: 11.17
2021 Fac PE RVU: 7.16

RUC Recommendation: 6.19 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14001 **Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,637

2021 Work RVU: 8.78
2021 NF PE RVU: 13.39
2021 Fac PE RVU: 8.68

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14020 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** April 2008 **2019 est Medicare Utilization:** 17,817

2021 Work RVU: 7.22
2021 NF PE RVU: 12.29
2021 Fac PE RVU: 8.16

RUC Recommendation: 7.02 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14021 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 19,350

2021 Work RVU: 9.72
2021 NF PE RVU: 14.29
2021 Fac PE RVU: 9.54

RUC Recommendation: 9.52 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14040 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 67,406

2021 Work RVU: 8.60
2021 NF PE RVU: 12.51
2021 Fac PE RVU: 8.42

RUC Recommendation: 8.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14041 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 45,011

2021 Work RVU: 10.83
2021 NF PE RVU: 14.84
2021 Fac PE RVU: 9.98

RUC Recommendation: 10.63 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14060 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 90,113

2021 Work RVU: 9.23
2021 NF PE RVU: 12.12
2021 Fac PE RVU: 8.93

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

14061 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 31,224

2021 Work RVU: 11.48
2021 NF PE RVU: 16.18
2021 Fac PE RVU: 10.86

RUC Recommendation: 11.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14300 **Deleted from CPT**

Global: **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14301 **Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm**

Global: 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 38,864

2021 Work RVU: 12.65
2021 NF PE RVU: 17.28
2021 Fac PE RVU: 10.74

RUC Recommendation: 12.47 **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

14302 **Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 40,086

2021 Work RVU: 3.73
2021 NF PE RVU: 1.96
2021 Fac PE RVU: 1.96

RUC Recommendation: 3.73 **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15002 **Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children**

Global: 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2014 **2019 est Medicare Utilization:** 24,066

2021 Work RVU: 3.65
2021 NF PE RVU: 6.16
2021 Fac PE RVU: 2.17

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15004 **Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children**

Global: 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 32,464

2021 Work RVU: 4.58
2021 NF PE RVU: 6.61
2021 Fac PE RVU: 2.44

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15100 **Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2014 **2019 est Medicare Utilization:** 13,549

2021 Work RVU: 9.90
2021 NF PE RVU: 13.91
2021 Fac PE RVU: 9.16

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15120 **Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

Global: 090 **Issue:** Autograft **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,650

2021 Work RVU: 10.15
2021 NF PE RVU: 13.24
2021 Fac PE RVU: 8.42

RUC Recommendation: Remove from screen

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15170 **Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15171 **Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15175 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15176 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

15220 **Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less**

Global: 090 **Issue:** Skin Graft **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,947

2021 Work RVU: 8.09
2021 NF PE RVU: 13.42
2021 Fac PE RVU: 8.53

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

15240 **Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS, AAD **First Identified:** January 2014 **2019 est Medicare Utilization:** 13,328

2021 Work RVU: 10.41
2021 NF PE RVU: 15.47
2021 Fac PE RVU: 11.30

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

15271 **Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 111,779

2021 Work RVU: 1.50
2021 NF PE RVU: 2.83
2021 Fac PE RVU: 0.73

RUC Recommendation: 1.50 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15272 **Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 14,569

2021 Work RVU: 0.33
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.12

RUC Recommendation: 0.59 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15273 **Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,775

2021 Work RVU: 3.50
2021 NF PE RVU: 5.22
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.50 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15274 **Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 25,402

2021 Work RVU: 0.80
2021 NF PE RVU: 1.48
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.80 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15275 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 122,551

2021 Work RVU: 1.83
2021 NF PE RVU: 2.68
2021 Fac PE RVU: 0.72

RUC Recommendation: 1.83 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15276 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 6,340

2021 Work RVU: 0.50
2021 NF PE RVU: 0.40
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.59 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15277 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,720

2021 Work RVU: 4.00
2021 NF PE RVU: 5.53
2021 Fac PE RVU: 1.89

RUC Recommendation: 4.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15278 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 2,936

2021 Work RVU: 1.00
2021 NF PE RVU: 1.65
2021 Fac PE RVU: 0.46

RUC Recommendation: 1.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15320 **Deleted from CPT**

Global: **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15321 **Deleted from CPT**

Global: **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15330 **Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Allograft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASPS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15331 **Deleted from CPT**

Global: **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15335 **Deleted from CPT**

Global: **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15336 **Deleted from CPT** **Global:** **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15360 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15361 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15365 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15366 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15400 **Deleted from CPT** **Global:** **Issue:** Xenograft **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15401 **Deleted from CPT** **Global:** **Issue:** Xenograft **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACS, ASPS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15420 **Deleted from CPT** **Global:** **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15421 **Deleted from CPT** **Global:** **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15570 **Formation of direct or tubed pedicle, with or without transfer; trunk** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 292

2021 Work RVU: 10.21
2021 NF PE RVU: 14.85
2021 Fac PE RVU: 9.36

RUC Recommendation: 10.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

15572 **Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 691

2021 Work RVU: 10.12
2021 NF PE RVU: 14.00
2021 Fac PE RVU: 9.64

RUC Recommendation: 9.94 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

15574 **Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,483

2021 Work RVU: 10.70
2021 NF PE RVU: 13.68
2021 Fac PE RVU: 9.34

RUC Recommendation: 10.52 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15576 **Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,346

2021 Work RVU: 9.37
2021 NF PE RVU: 12.76
2021 Fac PE RVU: 8.61

RUC Recommendation: 9.24 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15730 **Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** AAO **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,767

2021 Work RVU: 13.50
2021 NF PE RVU: 28.61
2021 Fac PE RVU: 11.48

RUC Recommendation: 13.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15731 **Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,362

2021 Work RVU: 14.38
2021 NF PE RVU: 16.41
2021 Fac PE RVU: 12.59

RUC Recommendation: Not part of family **Referred to CPT** September 2016 **Result:** Not Part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: **Issue:** Muscle Flaps **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** ASPS

First Identified: September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

15733 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** ASPS

First Identified: January 2017 **2019 est Medicare Utilization:** 5,657

2021 Work RVU: 15.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.20

RUC Recommendation: 15.68

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:**

First Identified: October 2015 **2019 est Medicare Utilization:** 24,232

2021 Work RVU: 23.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.46

RUC Recommendation: 23.00

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:** ASSH, ASPS

First Identified: January 2016 **2019 est Medicare Utilization:** 1,501

2021 Work RVU: 17.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.54

RUC Recommendation: 17.04 **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:** ASPS

First Identified: January 2016 **2019 est Medicare Utilization:** 6,218

2021 Work RVU: 19.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.12

RUC Recommendation: 19.04 **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15740 **Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel**

Global: 090 **Issue:** Dermatology and Plastic Surgery Procedures **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 28 **Specialty Developing Recommendation:** AAD, ASPS

First Identified: September 2007 **2019 est Medicare Utilization:** 2,046

2021 Work RVU: 11.80
2021 NF PE RVU: 15.93
2021 Fac PE RVU: 10.87

RUC Recommendation: 11.57 **Referred to CPT** February 2009 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15769 **Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)** **Global:** 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** AAOHNS, ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.24

RUC Recommendation: 6.68. Flagged for RAW review April 2022. **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15771 **Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate** **Global:** 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.73
2021 NF PE RVU: 8.97
2021 Fac PE RVU: 6.08

RUC Recommendation: 6.73 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15772 **Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 2.34
2021 Fac PE RVU: 1.15

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15773 **Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate**

Global: 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.83
2021 NF PE RVU: 9.01
2021 Fac PE RVU: 6.12

RUC Recommendation: 6.83 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15774 **Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.41
2021 NF PE RVU: 2.30
2021 Fac PE RVU: 1.11

RUC Recommendation: 2.41 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15777 **Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,429

2021 Work RVU: 3.65
2021 NF PE RVU: 1.97
2021 Fac PE RVU: 1.97

RUC Recommendation: 3.65 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15823 **Blepharoplasty, upper eyelid; with excessive skin weighting down lid**

Global: 090 **Issue:** Upper Eyelid Blepharoplasty **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 33 **Specialty Developing Recommendation:** AAO **First Identified:** October 2009 **2019 est Medicare Utilization:** 97,994

2021 Work RVU: 6.81
2021 NF PE RVU: 10.71
2021 Fac PE RVU: 8.60

RUC Recommendation: 6.81 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

16020 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 15,272

2021 Work RVU: 0.71
2021 NF PE RVU: 1.66
2021 Fac PE RVU: 0.77

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

16025 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 1,908

2021 Work RVU: 1.74
2021 NF PE RVU: 2.58
2021 Fac PE RVU: 1.22

RUC Recommendation: 1.85 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

16030 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACEP, ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 879

2021 Work RVU: 2.08
2021 NF PE RVU: 3.28
2021 Fac PE RVU: 1.38

RUC Recommendation: CPT Assistant article published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2012

Result: Maintain

17000 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion**

Global: 010 **Issue:** Destruction of Premalignant Lesions **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:** 6,117,793

2021 Work RVU: 0.61
2021 NF PE RVU: 1.27
2021 Fac PE RVU: 0.90

RUC Recommendation: 0.61

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

17003 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)**

Global: ZZZ **Issue:** Destruction of Premalignant Lesions **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:** 19,474,499

2021 Work RVU: 0.04
2021 NF PE RVU: 0.15
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.04

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

17004 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions**

Global: 010 **Issue:** Destruction of Premalignant Lesions **Screen:** CMS High Expenditure Procedural Codes1 / Modifer -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 874,685

2021 Work RVU: 1.37
2021 NF PE RVU: 3.35
2021 Fac PE RVU: 1.34

RUC Recommendation: Remove from Modifier -51 Exempt List. 1.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17106 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,933

2021 Work RVU: 3.69
2021 NF PE RVU: 5.92
2021 Fac PE RVU: 3.87

RUC Recommendation: 3.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17107 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,449

2021 Work RVU: 4.79
2021 NF PE RVU: 7.74
2021 Fac PE RVU: 5.00

RUC Recommendation: 4.68 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17108 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,081

2021 Work RVU: 7.49
2021 NF PE RVU: 10.10
2021 Fac PE RVU: 6.78

RUC Recommendation: 6.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17110 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions**

Global: 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 2,556,286

2021 Work RVU: 0.70
2021 NF PE RVU: 2.57
2021 Fac PE RVU: 1.15

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

17111 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions**

Global: 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 122,909

2021 Work RVU: 0.97
2021 NF PE RVU: 2.84
2021 Fac PE RVU: 1.29

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

17250 **Chemical cauterization of granulation tissue (ie, proud flesh)**

Global: 000 **Issue:** RAW **Screen:** High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, ACS, APMA

First Identified: October 2015

2019 est Medicare Utilization: 234,080

2021 Work RVU: 0.50
2021 NF PE RVU: 2.07
2021 Fac PE RVU: 0.50

RUC Recommendation: Review in 2 years (Oct 2021).

Referred to CPT September 2016
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Result:

Status Report: CMS Requests and Relativity Assessment Issues

17261 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 140,325

2021 Work RVU: 1.22
2021 NF PE RVU: 3.00
2021 Fac PE RVU: 1.17

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17262 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 287,333

2021 Work RVU: 1.63
2021 NF PE RVU: 3.45
2021 Fac PE RVU: 1.40

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17271 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 53,690

2021 Work RVU: 1.54
2021 NF PE RVU: 3.18
2021 Fac PE RVU: 1.35

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17272 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 82,281

2021 Work RVU: 1.82
2021 NF PE RVU: 3.54
2021 Fac PE RVU: 1.51

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17281 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 86,818

2021 Work RVU: 1.77
2021 NF PE RVU: 3.33
2021 Fac PE RVU: 1.48

RUC Recommendation: 1.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17282 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 81,831

2021 Work RVU: 2.09
2021 NF PE RVU: 3.74
2021 Fac PE RVU: 1.66

RUC Recommendation: 2.09 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17311 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 829,586

2021 Work RVU: 6.20
2021 NF PE RVU: 12.99
2021 Fac PE RVU: 3.57

RUC Recommendation: 6.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17312 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 509,267

2021 Work RVU: 3.30
2021 NF PE RVU: 8.41
2021 Fac PE RVU: 1.89

RUC Recommendation: 3.30 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17313 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 140,796

2021 Work RVU: 5.56
2021 NF PE RVU: 12.49
2021 Fac PE RVU: 3.20

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17314 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 57,990

2021 Work RVU: 3.06
2021 NF PE RVU: 8.16
2021 Fac PE RVU: 1.76

RUC Recommendation: 3.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17315 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 19,946

2021 Work RVU: 0.87
2021 NF PE RVU: 1.30
2021 Fac PE RVU: 0.50

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19020 **Mastotomy with exploration or drainage of abscess, deep** **Global:** 090 **Issue:** Mastotomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,614

2021 Work RVU: 3.83
2021 NF PE RVU: 9.57
2021 Fac PE RVU: 4.50

RUC Recommendation: Reduce 99238 to 0.5, remove hospital visits **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

19081 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance** **Global:** 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 60,561

2021 Work RVU: 3.29
2021 NF PE RVU: 13.26
2021 Fac PE RVU: 1.19

RUC Recommendation: 3.29 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19082 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 4,476

2021 Work RVU: 1.65
2021 NF PE RVU: 11.70
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.65 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19083 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 118,588

2021 Work RVU: 3.10
2021 NF PE RVU: 13.47
2021 Fac PE RVU: 1.12

RUC Recommendation: 3.10 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19084 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 15,269

2021 Work RVU: 1.55
2021 NF PE RVU: 11.57
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.55 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19085 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 5,634

2021 Work RVU: 3.64
2021 NF PE RVU: 22.01
2021 Fac PE RVU: 1.32

RUC Recommendation: 3.64 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19086 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,195

2021 Work RVU: 1.82
2021 NF PE RVU: 18.59
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.82 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19102 **Biopsy of breast; percutaneous, needle core, using imaging guidance**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

19103 **Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 30,514

2021 Work RVU: 2.00
2021 NF PE RVU: 5.08
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 3,292

2021 Work RVU: 1.00
2021 NF PE RVU: 4.08
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19283 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 3,526

2021 Work RVU: 2.00
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19284 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 338

2021 Work RVU: 1.00
2021 NF PE RVU: 4.98
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19285 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 25,714

2021 Work RVU: 1.70
2021 NF PE RVU: 10.83
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.70 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19286 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 2,002

2021 Work RVU: 0.85
2021 NF PE RVU: 9.77
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.85 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 266

2021 Work RVU: 2.55
2021 NF PE RVU: 19.02
2021 Fac PE RVU: 0.92

RUC Recommendation: 3.02 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 60

2021 Work RVU: 1.28
2021 NF PE RVU: 15.82
2021 Fac PE RVU: 0.46

RUC Recommendation: 1.51 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19290 **Preoperative placement of needle localization wire, breast;**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19291 **Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

19295 **Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)**

Global: **Issue:** Breast Biopsy **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

19303 **Mastectomy, simple, complete**

Global: 090 **Issue:** Mastectomy **Screen:** Site of Service Anomaly - 2015 / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACS, ASBS **First Identified:** October 2015 **2019 est Medicare Utilization:** 24,587

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.73

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19307 **Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle**

Global: 090 **Issue:** Modified Radical Mastectomy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 22 **Specialty Developing Recommendation:**

First Identified: October 2019

2019 est Medicare Utilization: 6,042

2021 Work RVU: 17.99
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.69

RUC Recommendation: 17.99

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

19318 **Breast reduction**

Global: 090 **Issue:** Mammaplasty **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASPS

First Identified: September 2007

2019 est Medicare Utilization: 7,501

2021 Work RVU: 16.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.22

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

19340 **Insertion of breast implant on same day of mastectomy (ie, immediate)**

Global: 090 **Issue:** Breast Implant/Expander Placement **Screen:** CMS Request / Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 05 **Specialty Developing Recommendation:** ASPS

First Identified: October 2009

2019 est Medicare Utilization: 7,433

2021 Work RVU: 10.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.81

RUC Recommendation: 11.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

19357 **Tissue expander placement in breast reconstruction, including subsequent expansion(s)**

Global: 090 **Issue:** Breast Implant/Expander Placement **Screen:** Site of Service Anomaly / 090-Day Global Post-Operative Visits / Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,479

2021 Work RVU: 14.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.67

RUC Recommendation: 15.36 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20000 **Deleted from CPT**

Global: **Issue:** Incision of Abcess **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

20005 **Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)**

Global: **Issue:** Incision of Deep Abscess **Screen:** Site of Service Anomaly / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20220 **Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)**

Global: 000 **Issue:** Bone Biopsy Trocar/Needle **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2018 **2019 est Medicare Utilization:** 12,355

2021 Work RVU: 1.65
2021 NF PE RVU: 5.58
2021 Fac PE RVU: 0.75

RUC Recommendation: 1.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20225 **Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)**

Global: 000 **Issue:** Bone Biopsy Trocar/Needle **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 14,341

2021 Work RVU: 2.45
2021 NF PE RVU: 9.49
2021 Fac PE RVU: 1.11

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20240 **Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)**

Global: 000 **Issue:** Bone Biopsy Excisional **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 04 **Specialty Developing Recommendation:** AAOS, APMA **First Identified:** April 2014 **2019 est Medicare Utilization:** 6,533

2021 Work RVU: 2.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20245 **Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)**

Global: 000 **Issue:** Bone Biopsy Excisional **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 04 **Specialty Developing Recommendation:** AAOS **First Identified:** January 2014 **2019 est Medicare Utilization:** 4,354

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.17

RUC Recommendation: 6.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20525 **Removal of foreign body in muscle or tendon sheath; deep or complicated** **Global:** 010 **Issue:** Removal of Foreign Body **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,693

2021 Work RVU: 3.54
2021 NF PE RVU: 10.08
2021 Fac PE RVU: 3.09

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

20526 **Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel** **Global:** 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** July 2016 **2019 est Medicare Utilization:** 102,673

2021 Work RVU: 0.94
2021 NF PE RVU: 1.27
2021 Fac PE RVU: 0.57

RUC Recommendation: Remove fromm screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

20550 **Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")** **Global:** 000 **Issue:** Injection of Tendon **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, AAPM&R, ACRh, APMA, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 848,059

2021 Work RVU: 0.75
2021 NF PE RVU: 0.80
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20551 **Injection(s); single tendon origin/insertion**

Global: 000 **Issue:** Therapeutic Injection Carpal Tunnel **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 10 **Specialty Developing Recommendation:** AAPMR, AAOS, ACRh, APMA, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 163,234

2021 Work RVU: 0.75
2021 NF PE RVU: 0.84
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20552 **Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)**

Global: 000 **Issue:** **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 28 **Specialty Developing Recommendation:** AAPM&R, ACRh, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 350,677

2021 Work RVU: 0.66
2021 NF PE RVU: 0.84
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.66 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20553 **Injection(s); single or multiple trigger point(s), 3 or more muscles**

Global: 000 **Issue:** **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 28 **Specialty Developing Recommendation:** AAPM&R, ACRh, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 378,100

2021 Work RVU: 0.75
2021 NF PE RVU: 0.98
2021 Fac PE RVU: 0.41

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20600 **Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** February 2010 **2019 est Medicare Utilization:** 444,325

2021 Work RVU: 0.66
2021 NF PE RVU: 0.77
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.66 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20604 **Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 46,354

2021 Work RVU: 0.89
2021 NF PE RVU: 1.38
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.89 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

20605 **Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** October 2009 **2019 est Medicare Utilization:** 466,622

2021 Work RVU: 0.68
2021 NF PE RVU: 0.81
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.68 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20606 **Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 56,334

2021 Work RVU: 1.00
2021 NF PE RVU: 1.47
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20610 **Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 / MPC List / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,722,382

2021 Work RVU: 0.79
2021 NF PE RVU: 0.96
2021 Fac PE RVU: 0.42

RUC Recommendation: 0.79 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

20611 **Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,069,935

2021 Work RVU: 1.10
2021 NF PE RVU: 1.65
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.10 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20612 **Aspiration and/or injection of ganglion cyst(s) any location**

Global: 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: July 2016

2019 est Medicare Utilization: 28,400

2021 Work RVU: 0.70
2021 NF PE RVU: 1.06
2021 Fac PE RVU: 0.41

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

20680 **Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, APMA

First Identified: January 2014

2019 est Medicare Utilization: 55,761

2021 Work RVU: 5.96
2021 NF PE RVU: 11.22
2021 Fac PE RVU: 5.36

RUC Recommendation: 5.96 and adjustments to pre-service time package 3.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

20692 **Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)**

Global: 090 **Issue:** RAW **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:**

First Identified: January 2014

2019 est Medicare Utilization: 3,150

2021 Work RVU: 16.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.87

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

20694 **Removal, under anesthesia, of external fixation system**

Global: 090 **Issue:** External Fixation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS

First Identified: September 2007 **2019 est Medicare Utilization:** 6,209

2021 Work RVU: 4.28
2021 NF PE RVU: 7.72
2021 Fac PE RVU: 4.95

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

20700 **Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA

First Identified: May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 0.68
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

20701 **Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA

First Identified: May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.13
2021 NF PE RVU: 0.51
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.13

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

20702 **Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA

First Identified: May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 1.14
2021 Fac PE RVU: 1.14

RUC Recommendation: 2.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

20703 **Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.80
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.80 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20704 **Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.60
2021 NF PE RVU: 1.19
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20705 **Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.15
2021 NF PE RVU: 0.98
2021 Fac PE RVU: 0.98

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20900 **Bone graft, any donor area; minor or small (eg, dowel or button)**

Global: 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,436

2021 Work RVU: 3.00
2021 NF PE RVU: 8.60
2021 Fac PE RVU: 1.85

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20902 **Bone graft, any donor area; major or large** **Global:** 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** April 2008 **2019 est Medicare Utilization:** 4,599

2021 Work RVU: 4.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.76

RUC Recommendation: 4.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20926 **Tissue grafts, other (eg, paratenon, fat, dermis)** **Global:** **Issue:** Tissue Grafting Procedures **Screen:** CMS Fastest Growing / Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** AAOS, ASPS, AANS, CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 14,815

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted for 2020

21015 **Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm** **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 506

2021 Work RVU: 9.89
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.04

RUC Recommendation: 9.71 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

21025 **Excision of bone (eg, for osteomyelitis or bone abscess); mandible** **Global:** 090 **Issue:** Excision of Bone – Mandible **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 61 **Specialty Developing Recommendation:** AAOMS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,614

2021 Work RVU: 10.03
2021 NF PE RVU: 12.52
2021 Fac PE RVU: 8.55

RUC Recommendation: 10.03 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21495 **Open treatment of hyoid fracture**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:**

First Identified: October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

21557 **Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS

First Identified: September 2007 **2019 est Medicare Utilization:** 490

2021 Work RVU: 14.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.39

RUC Recommendation: 14.57 **Referred to CPT** June 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

21800 **Closed treatment of rib fracture, uncomplicated, each**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS

First Identified: July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

21805 **Open treatment of rib fracture without fixation, each**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS

First Identified: January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21810 **Treatment of rib fracture requiring external fixation (flail chest)**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

21811 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 357

2021 Work RVU: 10.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.31

RUC Recommendation: 19.55 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

21812 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 468

2021 Work RVU: 13.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.32

RUC Recommendation: 25.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

21813 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 62

2021 Work RVU: 17.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.08

RUC Recommendation: 35.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21820 **Closed treatment of sternum fracture**

Global: 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** January 2014 **2019 est Medicare Utilization:** 190

2021 Work RVU: 1.36
2021 NF PE RVU: 2.76
2021 Fac PE RVU: 2.69

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** October 2013 **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

21825 **Open treatment of sternum fracture with or without skeletal fixation**

Global: 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 737

2021 Work RVU: 7.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.59

RUC Recommendation: Unrelated to the family **Referred to CPT** October 2013 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

21935 **Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 235

2021 Work RVU: 15.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.11

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22214 **Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 6,695

2021 Work RVU: 21.02
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.74

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22305 **Closed treatment of vertebral process fracture(s)**

Global: **Issue:** Closed treatment of vertebral process fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 23 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22310 **Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing**

Global: 090 **Issue:** Closed Treatment Vertebral Fracture **Screen:** Negative IWPUT / Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 23 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** April 2017 **2019 est Medicare Utilization:** 6,942

2021 Work RVU: 3.45
2021 NF PE RVU: 4.93
2021 Fac PE RVU: 4.53

RUC Recommendation: 3.45. Flag for Rereview **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22510 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 3,686

2021 Work RVU: 7.90
2021 NF PE RVU: 47.52
2021 Fac PE RVU: 3.71

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22511 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 4,104

2021 Work RVU: 7.33
2021 NF PE RVU: 47.95
2021 Fac PE RVU: 3.58

RUC Recommendation: 8.05 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22512 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 2,505

2021 Work RVU: 4.00
2021 NF PE RVU: 19.83
2021 Fac PE RVU: 1.42

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 24,396

2021 Work RVU: 8.65
2021 NF PE RVU: 185.14
2021 Fac PE RVU: 4.81

RUC Recommendation: 8.90 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 26,776

2021 Work RVU: 7.99
2021 NF PE RVU: 185.16
2021 Fac PE RVU: 4.57

RUC Recommendation: 8.24 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 15,688

2021 Work RVU: 4.00
2021 NF PE RVU: 100.20
2021 Fac PE RVU: 1.68

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22520 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22521 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Site of Service Anomaly (99238-Only); CMS Request - PE Inputs / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22522 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22523 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22524 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22525 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22533 **Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Arthrodesis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 908

2021 Work RVU: 24.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.10

RUC Recommendation: Remove from screen. CPT Assistant article published.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

22551 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 40,145

2021 Work RVU: 25.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.59

RUC Recommendation: 24.50

Referred to CPT October 2009

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22552 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 35,696

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.20

RUC Recommendation: 6.50

Referred to CPT October 2009

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22554 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,675

2021 Work RVU: 17.69
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.17

RUC Recommendation: 17.69 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22558 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** High Volume Growth2 / Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** April 2013 **2019 est Medicare Utilization:** 20,376

2021 Work RVU: 23.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.54

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

22585 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 17,132

2021 Work RVU: 5.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.57

RUC Recommendation: Remove from screen **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22612 **Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 44,894

2021 Work RVU: 23.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.98

RUC Recommendation: Review utilization data October 2015. 23.53. Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22614 **Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 144,296

2021 Work RVU: 6.43
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.19

RUC Recommendation: 6.43

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22630 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,654

2021 Work RVU: 22.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.38

RUC Recommendation: 22.09

Referred to CPT October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22632 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,875

2021 Work RVU: 5.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.56

RUC Recommendation: 5.22 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22633 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 38,096

2021 Work RVU: 27.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.89

RUC Recommendation: 27.75 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22634 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,338

2021 Work RVU: 8.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 8.16 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22843 **Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Spine Fixation Device **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 8,692

2021 Work RVU: 13.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.67

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

22849 **Reinsertion of spinal fixation device**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 4,231

2021 Work RVU: 19.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.05

RUC Recommendation: Maintain **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22851 **Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)**

Global: **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS Fastest Growing / High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22859 **Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,934

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.72

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22867 **Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level**

Global: 090 **Issue:** Insertion of Interlaminar/Interspinous Device **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - NPRM for 2021 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 26 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,131

2021 Work RVU: 13.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.54

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

22868 **Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 532

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.96

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22900 **Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 628

2021 Work RVU: 8.32
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.48

RUC Recommendation: 8.21 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

23076 **Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 677

2021 Work RVU: 7.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.02

RUC Recommendation: 7.28 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

23120 **Claviculectomy; partial**

Global: 090 **Issue:** Claviculectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 30 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,767

2021 Work RVU: 7.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.52

RUC Recommendation: 7.23 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

23130 **Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release**

Global: 090 **Issue:** Removal of Bone **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,826

2021 Work RVU: 7.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.95

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23350 **Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography**

Global: 000 **Issue:** Injection for Shoulder X-Ray **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** April 2011 **2019 est Medicare Utilization:** 35,070

2021 Work RVU: 1.00
2021 NF PE RVU: 3.80
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

23405 **Tenotomy, shoulder area; single tendon**

Global: 090 **Issue:** Tenotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,277

2021 Work RVU: 8.54
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.24

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

23410 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute**

Global: 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,333

2021 Work RVU: 11.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.61

RUC Recommendation: 11.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23412 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic**

Global: 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 12,002

2021 Work RVU: 11.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.91

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. 11.77 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23415 **Coracoacromial ligament release, with or without acromioplasty** **Global:** 090 **Issue:** Shoulder Ligament Release **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 62 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 408

2021 Work RVU: 9.23
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.58

RUC Recommendation: 9.23 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

23420 **Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,359

2021 Work RVU: 13.54
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.52

RUC Recommendation: 13.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

23430 **Tenodesis of long tendon of biceps** **Global:** 090 **Issue:** Tenodesis **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 19,997

2021 Work RVU: 10.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.89

RUC Recommendation: 10.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

23440 **Resection or transplantation of long tendon of biceps** **Global:** 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,487

2021 Work RVU: 10.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.61

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23472 **Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))**

Global: 090 **Issue:** Arthroplasty **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2019 est Medicare Utilization:** 67,382

2021 Work RVU: 22.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.29

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

23540 **Closed treatment of acromioclavicular dislocation; without manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 339

2021 Work RVU: 2.36
2021 NF PE RVU: 4.19
2021 Fac PE RVU: 4.11

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

23600 **Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation**

Global: 090 **Issue:** Treatment of Humerus Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 14 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2011 **2019 est Medicare Utilization:** 32,747

2021 Work RVU: 3.00
2021 NF PE RVU: 6.32
2021 Fac PE RVU: 5.76

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23625 **Closed treatment of greater humeral tuberosity fracture; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 173

2021 Work RVU: 4.10
2021 NF PE RVU: 6.43
2021 Fac PE RVU: 5.50

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

23650 **Closed treatment of shoulder dislocation, with manipulation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 14,692

2021 Work RVU: 3.53
2021 NF PE RVU: 5.37
2021 Fac PE RVU: 4.47

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

23655 **Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,327

2021 Work RVU: 4.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.41

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

23665 **Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 556

2021 Work RVU: 4.66
2021 NF PE RVU: 7.24
2021 Fac PE RVU: 6.24

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

24505 **Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 890

2021 Work RVU: 5.39
2021 NF PE RVU: 8.49
2021 Fac PE RVU: 6.96

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

24600 **Treatment of closed elbow dislocation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,283

2021 Work RVU: 4.37
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 4.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

24605 **Treatment of closed elbow dislocation; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 382

2021 Work RVU: 5.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.43

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

25116 **Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum**

Global: 090 **Issue:** Forearm Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 63 **Specialty Developing Recommendation:** ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,034

2021 Work RVU: 7.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 7.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25210 **Carpectomy; 1 bone**

Global: 090 **Issue:** Carpectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,150

2021 Work RVU: 6.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.35

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

25260 **Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 919

2021 Work RVU: 8.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.21

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

25280 **Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,402

2021 Work RVU: 7.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.02

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

25310 **Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon**

Global: 090 **Issue:** Forearm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 15 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,690

2021 Work RVU: 8.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.81

RUC Recommendation: 7.94 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

25565 **Closed treatment of radial and ulnar shaft fractures; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 667

2021 Work RVU: 5.85
2021 NF PE RVU: 8.38
2021 Fac PE RVU: 6.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

25605 **Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 20,527

2021 Work RVU: 6.25
2021 NF PE RVU: 8.59
2021 Fac PE RVU: 7.68

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

25606 **Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 2,015

2021 Work RVU: 8.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.77

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25607 **Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 9,419

2021 Work RVU: 9.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.43

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

25608 **Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 7,290

2021 Work RVU: 11.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.23

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25609 **Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** January 2014 **2019 est Medicare Utilization:** 18,114

2021 Work RVU: 14.38
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.92

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25675 **Closed treatment of distal radioulnar dislocation with manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 445

2021 Work RVU: 4.89
2021 NF PE RVU: 7.39
2021 Fac PE RVU: 6.10

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Result: PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26020 **Drainage of tendon sheath, digit and/or palm, each** **Global:** 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 2,453

2021 Work RVU: 6.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.34

RUC Recommendation: 7.79

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

26055 **Tendon sheath incision (eg, for trigger finger)** **Global:** 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 105,433

2021 Work RVU: 3.11
2021 NF PE RVU: 13.80
2021 Fac PE RVU: 4.93

RUC Recommendation: 3.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

26080 **Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each** **Global:** 090 **Issue:** RAW **Screen:** Site of Service Anomaly / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,997

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.50

RUC Recommendation: Action plan for RAW Oct 2015. Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2012

26160 **Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger** **Global:** 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 18,598

2021 Work RVU: 3.57
2021 NF PE RVU: 13.97
2021 Fac PE RVU: 5.13

RUC Recommendation: 3.57 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

26356 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,150

2021 Work RVU: 9.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.28

RUC Recommendation: 10.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

26357 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2014 **2019 est Medicare Utilization:** 66

2021 Work RVU: 11.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.25

RUC Recommendation: 11.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

26358 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2014 **2019 est Medicare Utilization:** 42

2021 Work RVU: 12.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.08

RUC Recommendation: 13.10 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

26480 **Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon**

Global: 090 **Issue:** Tendon Transfer **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 26 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 10,824

2021 Work RVU: 6.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.38

RUC Recommendation: 6.76 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

26700 **Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 471

2021 Work RVU: 3.83
2021 NF PE RVU: 5.38
2021 Fac PE RVU: 4.61

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26750 **Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,976

2021 Work RVU: 1.80
2021 NF PE RVU: 3.40
2021 Fac PE RVU: 3.43

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26755 **Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 522

2021 Work RVU: 3.23
2021 NF PE RVU: 5.67
2021 Fac PE RVU: 4.32

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

26770 **Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,900

2021 Work RVU: 3.15
2021 NF PE RVU: 4.68
2021 Fac PE RVU: 3.93

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27048 **Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 05 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 339

2021 Work RVU: 8.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.31

RUC Recommendation: 8.74 **Referred to CPT** June 2008 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

27062 **Excision; trochanteric bursa or calcification**

Global: 090 **Issue:** Trochanteric Bursa Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 32 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,884

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.60

RUC Recommendation: 5.66 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27096 **Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed**

Global: 000 **Issue:** Injection for Sacroiliac Joint **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 06 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ASIPP, ISIS, NASS **First Identified:** October 2009 **2019 est Medicare Utilization:** 489,612

2021 Work RVU: 1.48
2021 NF PE RVU: 3.26
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.48 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27130 **Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft**

Global: 090 **Issue:** Hip/Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 169,584

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.40

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27134 **Revision of total hip arthroplasty; both components, with or without autograft or allograft**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,863

2021 Work RVU: 30.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.86

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27193 **Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation**

Global: **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27194 **Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia**

Global: **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

27197 **Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation**

Global: 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:** 11,080

2021 Work RVU: 1.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.07

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27198 **Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)**

Global: 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:** 206

2021 Work RVU: 4.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.74

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27220 **Closed treatment of acetabulum (hip socket) fracture(s); without manipulation** **Global:** 090 **Issue:** Closed Treatment Fracture - Hip **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 08 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2017 **2019 est Medicare Utilization:** 3,070

2021 Work RVU: 5.50
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 5.61

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27230 **Closed treatment of femoral fracture, proximal end, neck; without manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,509

2021 Work RVU: 5.81
2021 NF PE RVU: 7.43
2021 Fac PE RVU: 7.17

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27232 **Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 194

2021 Work RVU: 11.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.83

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27236 **Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement** **Global:** 090 **Issue:** Open Treatment of Femoral Fracture **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2011 **2019 est Medicare Utilization:** 57,280

2021 Work RVU: 17.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.10

RUC Recommendation: 17.61 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27240 **Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 260

2021 Work RVU: 13.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27244 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2008 **2019 est Medicare Utilization:** 5,947

2021 Work RVU: 18.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.43

RUC Recommendation: 18.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

27245 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 83,430

2021 Work RVU: 18.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.41

RUC Recommendation: 18.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27250 **Closed treatment of hip dislocation, traumatic; without anesthesia**

Global: 000 **Issue:** Closed Treatment of Hip Dislocation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 18 **Specialty Developing Recommendation:** ACEP **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,180

2021 Work RVU: 3.82
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.73

RUC Recommendation: 3.82 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27252 **Closed treatment of hip dislocation, traumatic; requiring anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 762

2021 Work RVU: 11.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.11

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27265 **Closed treatment of post hip arthroplasty dislocation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 8,333

2021 Work RVU: 5.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.75

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27266 **Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,456

2021 Work RVU: 7.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.98

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27279 **Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device** **Global:** 090 **Issue:** Arthodesis - Sacroiliac Joint **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 09 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** July 2017 **2019 est Medicare Utilization:** 3,753

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.28

RUC Recommendation: 9.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27324 **Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)** **Global:** 090 **Issue:** Soft Tissue Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 814

2021 Work RVU: 5.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.87

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

27369 **Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography** **Global:** 000 **Issue:** Knee Arthrography Injection **Screen:** Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 05 **Specialty Developing Recommendation:** ACR **First Identified:** June 2017 **2019 est Medicare Utilization:** 60,267

2021 Work RVU: 0.77
2021 NF PE RVU: 4.22
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.96 **Referred to CPT** February 2018 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27370 **Injection of contrast for knee arthrography** **Global:** **Issue:** Knee Arthrography Injection **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 05 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Bulletin #1 2010

Status Report: CMS Requests and Relativity Assessment Issues

27446 **Arthroplasty, knee, condyle and plateau; medial OR lateral compartment**

Global: 090 **Issue:** Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / Harvard-Valued with Annual Allowed Charges Greater than $10 million / Site of Service Anomaly - 2020 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 15,803

2021 Work RVU: 17.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.11

RUC Recommendation: 17.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

27447 **Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)**

Global: 090 **Issue:** Hip/Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 312,130

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.37

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27502 **Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 385

2021 Work RVU: 11.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.76

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27510 **Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 386

2021 Work RVU: 9.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.41

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27550 **Closed treatment of knee dislocation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 531

2021 Work RVU: 5.98
2021 NF PE RVU: 8.46
2021 Fac PE RVU: 7.25

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27552 **Closed treatment of knee dislocation; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 269

2021 Work RVU: 8.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.95

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27615 **Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm**

Global: 090 **Issue:** Radical Resecion of Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 211

2021 Work RVU: 15.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.22

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27619 **Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 552

2021 Work RVU: 6.91
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.54

RUC Recommendation: 6.80 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27640 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,673

2021 Work RVU: 12.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.13

RUC Recommendation: 12.10 **Referred to CPT** June 2008 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27641 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 905

2021 Work RVU: 9.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.91

RUC Recommendation: 9.72 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27650 **Repair, primary, open or percutaneous, ruptured Achilles tendon;**

Global: 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 20 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,516

2021 Work RVU: 9.21
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.78

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27654 **Repair, secondary, Achilles tendon, with or without graft**

Global: 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 33 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,117

2021 Work RVU: 10.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 10.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27685 **Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,084

2021 Work RVU: 6.69
2021 NF PE RVU: 12.08
2021 Fac PE RVU: 6.05

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

27687 **Gastrocnemius recession (eg, Strayer procedure)**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,093

2021 Work RVU: 6.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.02

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

27690 **Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,376

2021 Work RVU: 9.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.39

RUC Recommendation: 8.96 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27691 **Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,579

2021 Work RVU: 10.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.72

RUC Recommendation: 10.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27752 **Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,229

2021 Work RVU: 6.27
2021 NF PE RVU: 8.42
2021 Fac PE RVU: 7.06

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27762 **Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 369

2021 Work RVU: 5.47
2021 NF PE RVU: 7.69
2021 Fac PE RVU: 6.33

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27792 **Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed**

Global: 090 **Issue:** Treatment of Ankle Fracture **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, **First Identified:** June 2010 **2019 est Medicare Utilization:** 7,279

2021 Work RVU: 8.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.74

RUC Recommendation: 9.71 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27810 **Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,962

2021 Work RVU: 5.32
2021 NF PE RVU: 7.64
2021 Fac PE RVU: 6.25

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27814 **Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,858

2021 Work RVU: 10.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.01

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27818 **Closed treatment of trimalleolar ankle fracture; with manipulation**

Global: 090 **Issue:** Treatment of Fracture **Screen:** Site of Service Anomaly (99238-Only) / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,490

2021 Work RVU: 5.69
2021 NF PE RVU: 7.71
2021 Fac PE RVU: 6.15

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27825 **Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 659

2021 Work RVU: 6.69
2021 NF PE RVU: 8.17
2021 Fac PE RVU: 6.59

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27840 **Closed treatment of ankle dislocation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,234

2021 Work RVU: 4.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.53

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

28001 **Incision and drainage, bursa, foot**

Global: 010 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** April 2020 **2019 est Medicare Utilization:** 3,770

2021 Work RVU: 2.78
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 1.87

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28002 **Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space**

Global: 010 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 6,661

2021 Work RVU: 5.34
2021 NF PE RVU: 7.01
2021 Fac PE RVU: 3.34

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28003 **Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas**

Global: 090 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** April 2020 **2019 est Medicare Utilization:** 5,470

2021 Work RVU: 9.06
2021 NF PE RVU: 10.59
2021 Fac PE RVU: 6.33

RUC Recommendation: 5.28 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28111 **Ostectomy, complete excision; first metatarsal head**

Global: 090 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,069

2021 Work RVU: 5.15
2021 NF PE RVU: 8.71
2021 Fac PE RVU: 3.71

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28120 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,154

2021 Work RVU: 7.31
2021 NF PE RVU: 11.80
2021 Fac PE RVU: 6.30

RUC Recommendation: 8.27 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

28122 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 14,469

2021 Work RVU: 6.76
2021 NF PE RVU: 10.10
2021 Fac PE RVU: 5.30

RUC Recommendation: 7.72 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28124 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe**

Global: 090 **Issue:** Toe Removal **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 11,425

2021 Work RVU: 5.00
2021 NF PE RVU: 8.71
2021 Fac PE RVU: 4.25

RUC Recommendation: Remove 99238 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28285 **Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)**

Global: 090 **Issue:** Orthopaedic Surgery/Podiatry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 71,537

2021 Work RVU: 5.62
2021 NF PE RVU: 9.73
2021 Fac PE RVU: 4.95

RUC Recommendation: 5.62 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

28289 **Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,662

2021 Work RVU: 6.90
2021 NF PE RVU: 13.18
2021 Fac PE RVU: 5.72

RUC Recommendation: 6.90 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28290 **Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

28291 **Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,067

2021 Work RVU: 8.01
2021 NF PE RVU: 12.74
2021 Fac PE RVU: 5.60

RUC Recommendation: 8.01 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28292 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,950

2021 Work RVU: 7.44
2021 NF PE RVU: 12.86
2021 Fac PE RVU: 5.88

RUC Recommendation: 7.44 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

28293 **Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

28294 **Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure)**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28295 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 586

2021 Work RVU: 8.57
2021 NF PE RVU: 23.38
2021 Fac PE RVU: 8.29

RUC Recommendation: 8.57 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28296 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,559

2021 Work RVU: 8.25
2021 NF PE RVU: 17.86
2021 Fac PE RVU: 5.94

RUC Recommendation: 8.25 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28297 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,793

2021 Work RVU: 9.29
2021 NF PE RVU: 20.85
2021 Fac PE RVU: 7.24

RUC Recommendation: 9.29 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28298 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,903

2021 Work RVU: 7.75
2021 NF PE RVU: 16.46
2021 Fac PE RVU: 6.00

RUC Recommendation: 7.75 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28299 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,743

2021 Work RVU: 9.29
2021 NF PE RVU: 19.90
2021 Fac PE RVU: 6.82

RUC Recommendation: 9.29 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28300 **Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation**

Global: 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,519

2021 Work RVU: 9.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.88

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28310 **Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)**

Global: 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,640

2021 Work RVU: 5.57
2021 NF PE RVU: 10.09
2021 Fac PE RVU: 4.37

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28470 **Closed treatment of metatarsal fracture; without manipulation, each**

Global: 090 **Issue:** Treatment of Metatarsal Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 15 **Specialty Developing Recommendation:** AAOS, APMA, AOFAS **First Identified:** April 2011 **2019 est Medicare Utilization:** 29,629

2021 Work RVU: 2.03
2021 NF PE RVU: 4.14
2021 Fac PE RVU: 3.72

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28660 **Closed treatment of interphalangeal joint dislocation; without anesthesia**

Global: 010 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 689

2021 Work RVU: 1.28
2021 NF PE RVU: 2.07
2021 Fac PE RVU: 1.21

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

28725 **Arthrodesis; subtalar**

Global: 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,389

2021 Work RVU: 11.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.84

RUC Recommendation: 12.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28730 **Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;**

Global: 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,581

2021 Work RVU: 10.70
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.25

RUC Recommendation: 12.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28740 **Arthrodesis, midtarsal or tarsometatarsal, single joint**

Global: 090 **Issue:** Arthrodesis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,996

2021 Work RVU: 9.29
2021 NF PE RVU: 14.18
2021 Fac PE RVU: 7.58

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28820 **Amputation, toe; metatarsophalangeal joint**

Global: 090 **Issue:** Toe Amputation **Screen:** Site of Service Anomaly - 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACS, AOFAS, APMA, SVS **First Identified:** October 2018 **2019 est Medicare Utilization:** 30,702

2021 Work RVU: 3.51
2021 NF PE RVU: 5.16
2021 Fac PE RVU: 1.34

RUC Recommendation: 4.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28825 **Amputation, toe; interphalangeal joint**

Global: 090 **Issue:** Toe Amputation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACS, AOFAS, APMA, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 15,013

2021 Work RVU: 3.41
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 1.30

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29075 **Application, cast; elbow to finger (short arm)**

Global: 000 **Issue:** Application of Forearm Cast **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 16 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** April 2011 **2019 est Medicare Utilization:** 68,396

2021 Work RVU: 0.77
2021 NF PE RVU: 1.62
2021 Fac PE RVU: 0.90

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29105 **Application of long arm splint (shoulder to hand)**

Global: 000 **Issue:** Application of Long Arm Splint **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACEP, ASSH **First Identified:** July 2016 **2019 est Medicare Utilization:** 25,626

2021 Work RVU: 0.80
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29200 **Strapping; thorax**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,693

2021 Work RVU: 0.39
2021 NF PE RVU: 0.56
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29220 **Deleted from CPT**

Global: **Issue:** Strapping; low back **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT, no further action necessary

---

29240 **Strapping; shoulder (eg, Velpeau)**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 16,307

2021 Work RVU: 0.39
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29260 **Strapping; elbow or wrist**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** October 2013 **2019 est Medicare Utilization:** 5,004

2021 Work RVU: 0.39
2021 NF PE RVU: 0.45
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29280 **Strapping; hand or finger**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** October 2013 **2019 est Medicare Utilization:** 3,404

2021 Work RVU: 0.39
2021 NF PE RVU: 0.43
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29445 **Application of rigid total contact leg cast**

Global: 000 **Issue:** Application of Rigid Leg Cast **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, AHKNS, AOFAS, AOA, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 36,431

2021 Work RVU: 1.78
2021 NF PE RVU: 1.78
2021 Fac PE RVU: 0.94

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29520 **Strapping; hip**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,018

2021 Work RVU: 0.39
2021 NF PE RVU: 0.64
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29530 **Strapping; knee**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 27,045

2021 Work RVU: 0.39
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.12

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29540 **Strapping; ankle and/or foot**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41ii **Specialty Developing Recommendation:** APMA **First Identified:** October 2009 **2019 est Medicare Utilization:** 213,060

2021 Work RVU: 0.39
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.09

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29550 **Strapping; toes**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41ii **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 56,200

2021 Work RVU: 0.25
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29580 **Strapping; Unna boot**

Global: 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 265,752

2021 Work RVU: 0.55
2021 NF PE RVU: 1.26
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29581 **Application of multi-layer compression system; leg (below knee), including ankle and foot**

Global: 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 194,064

2021 Work RVU: 0.60
2021 NF PE RVU: 2.03
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29582 **Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed**

Global: **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

29583 **Application of multi-layer compression system; upper arm and forearm**

Global: **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

Status Report: CMS Requests and Relativity Assessment Issues

29584 **Application of multi-layer compression system; upper arm, forearm, hand, and fingers**

Global: 000 **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 27 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,715

2021 Work RVU: 0.35
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.10

RUC Recommendation: Develop CPT Assistant Article **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

29590 **Denis-Browne splint strapping**

Global: **Issue:** Dennis-Browne splint revision **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

29805 **Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 698

2021 Work RVU: 6.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.74

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29822 **Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])**

Global: 090 **Issue:** Shoulder Debridement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 11 **Specialty Developing Recommendation:**

First Identified: October 2008 **2019 est Medicare Utilization:** 9,153

2021 Work RVU: 7.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.61

RUC Recommendation: 7.03 **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29823 **Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])**

Global: 090 **Issue:** Shoulder Debridement **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization over 30,000-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 11 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 45,349

2021 Work RVU: 7.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.03

RUC Recommendation: 7.98 **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29824 **Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)**

Global: 090 **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS

First Identified: February 2010 **2019 est Medicare Utilization:** 39,895

2021 Work RVU: 8.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.29

RUC Recommendation: 8.82 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29826 **Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 78,655

2021 Work RVU: 3.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.52

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29827 **Arthroscopy, shoulder, surgical; with rotator cuff repair**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing/ Codes Reported Together 75% or More-Part1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2019 est Medicare Utilization:** 69,465

2021 Work RVU: 15.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.97

RUC Recommendation: 15.59. Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29828 **Arthroscopy, shoulder, surgical; biceps tenodesis**

Global: 090 **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 18,992

2021 Work RVU: 13.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.38

RUC Recommendation: 13.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29830 **Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 136

2021 Work RVU: 5.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.50

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29840 **Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 125

2021 Work RVU: 5.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.66

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29870 **Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 13 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 1,031

2021 Work RVU: 5.19
2021 NF PE RVU: 10.58
2021 Fac PE RVU: 5.85

RUC Recommendation: New PE non-facility inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29888 **Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction**

Global: 090 **Issue:** ACL Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 38 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,173

2021 Work RVU: 14.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.84

RUC Recommendation: 14.14 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29900 **Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 4

2021 Work RVU: 5.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.79

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

30140 **Submucous resection inferior turbinate, partial or complete, any method** **Global:** 000 **Issue:** Resection of Inferior Turbinate **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 14 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 49,954

2021 Work RVU: 3.00
2021 NF PE RVU: 5.28
2021 Fac PE RVU: 1.75

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

30465 **Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)** **Global:** 090 **Issue:** Repair Nasal Stenosis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,626

2021 Work RVU: 12.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.15

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

30901 **Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 88,372

2021 Work RVU: 1.10
2021 NF PE RVU: 3.36
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 48,496

2021 Work RVU: 1.54
2021 NF PE RVU: 5.49
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 5,245

2021 Work RVU: 1.97
2021 NF PE RVU: 8.29
2021 Fac PE RVU: 0.78

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 800

2021 Work RVU: 2.45
2021 NF PE RVU: 8.13
2021 Fac PE RVU: 1.14

RUC Recommendation: 2.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31231 **Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2010 **2019 est Medicare Utilization:** 660,545

2021 Work RVU: 1.10
2021 NF PE RVU: 4.54
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31237 **Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 137,754

2021 Work RVU: 2.60
2021 NF PE RVU: 4.56
2021 Fac PE RVU: 1.65

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31238 **Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 29,505

2021 Work RVU: 2.74
2021 NF PE RVU: 4.25
2021 Fac PE RVU: 1.71

RUC Recommendation: 2.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31239 **Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy**

Global: 010 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,366

2021 Work RVU: 9.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.80

RUC Recommendation: 9.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31240 **Nasal/sinus endoscopy, surgical; with concha bullosa resection**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 6,458

2021 Work RVU: 2.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.62

RUC Recommendation: 2.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31241 **Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 470

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.78

RUC Recommendation: 8.51 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31253 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,502

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.26

RUC Recommendation: 9.00 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31254 **Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 13,255

2021 Work RVU: 4.27
2021 NF PE RVU: 8.03
2021 Fac PE RVU: 2.19

RUC Recommendation: 4.27 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31255 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 11,287

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.84

RUC Recommendation: 5.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31256 **Nasal/sinus endoscopy, surgical, with maxillary antrostomy;**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 15,592

2021 Work RVU: 3.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.68

RUC Recommendation: 3.11 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31257 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 5,920

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.83

RUC Recommendation: 8.00 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31259 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 7,903

2021 Work RVU: 8.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 8.48 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31267 **Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 28,703

2021 Work RVU: 4.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.68 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31276 **Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 15,859

2021 Work RVU: 6.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.27

RUC Recommendation: 6.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31287 **Nasal/sinus endoscopy, surgical, with sphenoidotomy;**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 3,280

2021 Work RVU: 3.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.84

RUC Recommendation: 3.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31288 **Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,121

2021 Work RVU: 4.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.11

RUC Recommendation: 4.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31295 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 28,533

2021 Work RVU: 2.70
2021 NF PE RVU: 52.30
2021 Fac PE RVU: 1.50

RUC Recommendation: 2.70 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31296 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,725

2021 Work RVU: 3.10
2021 NF PE RVU: 52.59
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31297 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 2,120

2021 Work RVU: 2.44
2021 NF PE RVU: 52.17
2021 Fac PE RVU: 1.38

RUC Recommendation: 2.44 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31298 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 19,499

2021 Work RVU: 4.50
2021 NF PE RVU: 99.88
2021 Fac PE RVU: 2.28

RUC Recommendation: 4.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31500 **Intubation, endotracheal, emergency procedure**

Global: 000 **Issue:** Endotracheal Intubation **Screen:** CMS High Expenditure Procedural Codes2 / Modifer -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 27 **Specialty Developing Recommendation:** ACEP, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 263,123

2021 Work RVU: 3.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.72

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2016

Status Report: CMS Requests and Relativity Assessment Issues

31551 **Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 2

2021 Work RVU: 21.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 20.58

RUC Recommendation: 21.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31552 **Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 12

2021 Work RVU: 20.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 20.16

RUC Recommendation: 20.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31553 **Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU: 22.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.58

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31554 **Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 23

2021 Work RVU: 22.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.60

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31571 **Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope**

Global: 000 **Issue:** Laryngoscopy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2007 **2019 est Medicare Utilization:** 5,271

2021 Work RVU: 4.26
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.32

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

31575 **Laryngoscopy, flexible; diagnostic**

Global: 000 **Issue:** **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 08 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2010 **2019 est Medicare Utilization:** 658,434

2021 Work RVU: 0.94
2021 NF PE RVU: 2.69
2021 Fac PE RVU: 0.87

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

31579 **Laryngoscopy, flexible or rigid telescopic, with stroboscopy**

Global: 000 **Issue:** Laryngoscopy **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 08 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2008 **2019 est Medicare Utilization:** 86,928

2021 Work RVU: 1.88
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 1.31

RUC Recommendation: 1.94

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

31580 **Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 21

2021 Work RVU: 14.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.35

RUC Recommendation: 14.60 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31582 **Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31584 **Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 15

2021 Work RVU: 17.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.83

RUC Recommendation: 20.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31587 **Laryngoplasty, cricoid split, without graft placement**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 15

2021 Work RVU: 15.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.87

RUC Recommendation: 15.27 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31588 **Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31591 **Laryngoplasty, medialization, unilateral**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,148

2021 Work RVU: 13.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.65

RUC Recommendation: 15.60 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31592 **Cricotracheal resection**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 23

2021 Work RVU: 25.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 22.15

RUC Recommendation: 25.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31600 **Tracheostomy, planned (separate procedure);**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 23,498

2021 Work RVU: 5.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.38

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31601 **Tracheostomy, planned (separate procedure); younger than 2 years**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 4

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.93

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31603 **Tracheostomy, emergency procedure; transtracheal**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 801

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.34

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31605 **Tracheostomy, emergency procedure; cricothyroid membrane**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 278

2021 Work RVU: 6.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.02

RUC Recommendation: 6.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31610 **Tracheostomy, fenestration procedure with skin flaps**

Global: 090 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 15 **Specialty Developing Recommendation:** AAOHNS, ACS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,593

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.66

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31611 **Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)**

Global: 090 **Issue:** Speech Prosthesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 761

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.01

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

31620 **Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])**

Global: **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31622 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 52,315

2021 Work RVU: 2.53
2021 NF PE RVU: 4.51
2021 Fac PE RVU: 1.03

RUC Recommendation: 2.78 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31623 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings**

Global: 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2016 **2019 est Medicare Utilization:** 26,278

2021 Work RVU: 2.63
2021 NF PE RVU: 5.36
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31624 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage**

Global: 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2019 est Medicare Utilization:** 118,565

2021 Work RVU: 2.63
2021 NF PE RVU: 4.74
2021 Fac PE RVU: 1.04

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31625 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2013 **2019 est Medicare Utilization:** 19,149

2021 Work RVU: 3.11
2021 NF PE RVU: 7.16
2021 Fac PE RVU: 1.17

RUC Recommendation: 3.36 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31626 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,173

2021 Work RVU: 3.91
2021 NF PE RVU: 21.01
2021 Fac PE RVU: 1.42

RUC Recommendation: 4.16 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31628 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 32,291

2021 Work RVU: 3.55
2021 NF PE RVU: 7.37
2021 Fac PE RVU: 1.30

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31629 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,745

2021 Work RVU: 3.75
2021 NF PE RVU: 9.78
2021 Fac PE RVU: 1.36

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31632 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,890

2021 Work RVU: 1.03
2021 NF PE RVU: 0.77
2021 Fac PE RVU: 0.32

RUC Recommendation: 1.03 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31633 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,196

2021 Work RVU: 1.32
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31645 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 08 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2015 **2019 est Medicare Utilization:** 35,233

2021 Work RVU: 2.88
2021 NF PE RVU: 4.90
2021 Fac PE RVU: 1.13

RUC Recommendation: 2.88 **Referred to CPT** May 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31646 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 08 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,580

2021 Work RVU: 2.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.09

RUC Recommendation: 2.78 **Referred to CPT** May 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

31652 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 25,507

2021 Work RVU: 4.46
2021 NF PE RVU: 32.45
2021 Fac PE RVU: 1.59

RUC Recommendation: 5.00 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31653 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 13,988

2021 Work RVU: 4.96
2021 NF PE RVU: 33.33
2021 Fac PE RVU: 1.74

RUC Recommendation: 5.50 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31654 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])**

Global: ZZZ **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 8,214

2021 Work RVU: 1.40
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.70 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

32201 **Pneumonostomy; with percutaneous drainage of abscess or cyst**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32405 **Biopsy, lung or mediastinum, percutaneous needle**

Global: 000 **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 70,068

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32408 **Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed**

Global: 000 **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** April 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 3.18
2021 NF PE RVU: 24.27
2021 Fac PE RVU: 1.00

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

32420 **Pneumocentesis, puncture of lung for aspiration**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32421 **Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32422 **Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32440 **Removal of lung, pneumonectomy;**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 247

2021 Work RVU: 27.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.36

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32480 **Removal of lung, other than pneumonectomy; single lobe (lobectomy)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 4,630

2021 Work RVU: 25.82
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.53

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

32482 **Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 294

2021 Work RVU: 27.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.58

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

32491 **Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 15

2021 Work RVU: 25.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.02

RUC Recommendation: Request further information from CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32551 **Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)**

Global: 000 **Issue:** Chest Tube Thoracostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** April 2011 **2019 est Medicare Utilization:** 33,044

2021 Work RVU: 3.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.01

RUC Recommendation: 3.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

32554 **Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 13,649

2021 Work RVU: 1.82
2021 NF PE RVU: 5.07
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.82 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32555 **Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 229,865

2021 Work RVU: 2.27
2021 NF PE RVU: 7.14
2021 Fac PE RVU: 0.75

RUC Recommendation: 2.27 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32556 **Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,833

2021 Work RVU: 2.50
2021 NF PE RVU: 19.31
2021 Fac PE RVU: 0.80

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32557 **Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 38,244

2021 Work RVU: 3.12
2021 NF PE RVU: 16.44
2021 Fac PE RVU: 0.98

RUC Recommendation: 3.62 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32663 **Thoracoscopy, surgical; with lobectomy (single lobe)**

Global: 090 **Issue:** RAW review **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** STS **First Identified:** October 2008 **2019 est Medicare Utilization:** 9,229

2021 Work RVU: 24.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.61

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

33010 **Pericardiocentesis; initial**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 6,698

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33011 **Pericardiocentesis; subsequent**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 87

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33015 **Tube pericardiostomy**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2017 **2019 est Medicare Utilization:** 1,147

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33016 **Pericardiocentesis, including imaging guidance, when performed**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 5.00 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

33017 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.60

RUC Recommendation: 5.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33018 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age or any age with congenital cardiac anomaly**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 5.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 6.00 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

33019 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.49

RUC Recommendation: 5.00 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

33020 **Pericardiotomy for removal of clot or foreign body (primary procedure)**

Global: 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 10 **Specialty Developing Recommendation:** AATS, STS **First Identified:** April 2018 **2019 est Medicare Utilization:** 122

2021 Work RVU: 14.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.59

RUC Recommendation: 14.31 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33025 **Creation of pericardial window or partial resection for drainage**

Global: 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 10 **Specialty Developing Recommendation:** AATS, STS **First Identified:** April 2017 **2019 est Medicare Utilization:** 4,535

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.29

RUC Recommendation: 13.20 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33207 **Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,733

2021 Work RVU: 7.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.56

RUC Recommendation: 8.05 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33208 **Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 103,628

2021 Work RVU: 8.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.88

RUC Recommendation: 8.77 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33212 **Insertion of pacemaker pulse generator only; with existing single lead**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 317

2021 Work RVU: 5.01
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.37

RUC Recommendation: 5.26 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33213 **Insertion of pacemaker pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,113

2021 Work RVU: 5.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.43

RUC Recommendation: 5.53 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33221 **Insertion of pacemaker pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 268

2021 Work RVU: 5.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.87

RUC Recommendation: 5.80 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33227 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 3,452

2021 Work RVU: 5.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.56

RUC Recommendation: 5.50 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33228 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 24,395

2021 Work RVU: 5.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.68

RUC Recommendation: 5.77 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33229 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,526

2021 Work RVU: 5.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.96

RUC Recommendation: 6.04 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33230 **Insertion of implantable defibrillator pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 140

2021 Work RVU: 6.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.86

RUC Recommendation: 6.32 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33231 **Insertion of implantable defibrillator pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2011

2019 est Medicare Utilization: 121

2021 Work RVU: 6.34
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 6.59

Referred to CPT February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33233 **Removal of permanent pacemaker pulse generator only**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC

First Identified: February 2010

2019 est Medicare Utilization: 8,743

2021 Work RVU: 3.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.01

RUC Recommendation: 3.39

Referred to CPT February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33240 **Insertion of implantable defibrillator pulse generator only; with existing single lead**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: February 2010

2019 est Medicare Utilization: 217

2021 Work RVU: 5.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.64

RUC Recommendation: 6.06

Referred to CPT February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33241 **Removal of implantable defibrillator pulse generator only**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC

First Identified: February 2010

2019 est Medicare Utilization: 6,043

2021 Work RVU: 3.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.61

RUC Recommendation: 3.29

Referred to CPT February 2011

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33249 **Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC

First Identified: February 2010

2019 est Medicare Utilization: 42,661

2021 Work RVU: 14.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.73

RUC Recommendation: 15.17

Referred to CPT February 2011

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33262 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2011

2019 est Medicare Utilization: 3,000

2021 Work RVU: 5.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.90

RUC Recommendation: 6.06

Referred to CPT February 2011

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33263 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2011

2019 est Medicare Utilization: 7,980

2021 Work RVU: 6.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.01

RUC Recommendation: 6.33

Referred to CPT February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33264 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2011

2019 est Medicare Utilization: 11,831

2021 Work RVU: 6.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.17

RUC Recommendation: 6.60

Referred to CPT February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33282 **Implantation of patient-activated cardiac event recorder**

Global: **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 3.50

Referred to CPT February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33284 **Removal of an implantable, patient-activated cardiac event recorder**

Global: **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 3.00 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33405 **Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011 **2019 est Medicare Utilization:** 17,344

2021 Work RVU: 41.32
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.58

RUC Recommendation: 41.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33430 **Replacement, mitral valve, with cardiopulmonary bypass**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** High IWPUT / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: February 2008 **2019 est Medicare Utilization:** 7,658

2021 Work RVU: 50.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.29

RUC Recommendation: 50.93 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33533 **Coronary artery bypass, using arterial graft(s); single arterial graft**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011 **2019 est Medicare Utilization:** 60,180

2021 Work RVU: 33.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.23

RUC Recommendation: 34.98 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

33620 **Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:** 56

2021 Work RVU: 30.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.30

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

33621 **Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:**

2021 Work RVU: 16.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.30

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

Status Report: CMS Requests and Relativity Assessment Issues

33622 **Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS **First Identified:** January 2015 **2019 est Medicare Utilization:** 1

2021 Work RVU: 64.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.49

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

33741 **Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 14.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.98

RUC Recommendation: 14.00

Referred to CPT September 2019 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33745 **Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 20.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.24

RUC Recommendation: 20.00

Referred to CPT September 2019 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33746 **Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.88

RUC Recommendation: 10.50 **Referred to CPT** September 2019 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33863 **Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)**

Global: 090 **Issue:** Aortic Graft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** STS, AATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,812

2021 Work RVU: 58.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.72

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

33945 **Heart transplant, with or without recipient cardiectomy**

Global: 090 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 667

2021 Work RVU: 89.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 31.88

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33946 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2014 **2019 est Medicare Utilization:** 603

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.82

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33947 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 1,395

2021 Work RVU: 6.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.00

RUC Recommendation: 6.63 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33948 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 4,436

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.49

RUC Recommendation: 4.73 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33949 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial**

Global: XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 5,342

2021 Work RVU: 4.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 4.60 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33951 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 1

2021 Work RVU: 8.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33952 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 1,439

2021 Work RVU: 8.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.56

RUC Recommendation: 8.43 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33953 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:**

2021 Work RVU: 9.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.63

RUC Recommendation: 9.83 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33954 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 354

2021 Work RVU: 9.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.43 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 352

2021 Work RVU: 16.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.73

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33958 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 72

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.05 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33959 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.69 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33960 **Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33961 **Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33962 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 20

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.73 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33963 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.60

RUC Recommendation: 9.00 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33964 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 22

2021 Work RVU: 9.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 3.51 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33966 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 383

2021 Work RVU: 4.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.44

RUC Recommendation: 4.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33969 **Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 5.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.56

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 543

2021 Work RVU: 5.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.58

RUC Recommendation: 6.38 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 1

2021 Work RVU: 9.89
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.85

RUC Recommendation: 9.89 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 221

2021 Work RVU: 10.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.99

RUC Recommendation: 10.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 41

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.13

RUC Recommendation: 4.08 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 40

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 15.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33989 **Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 14

2021 Work RVU: 9.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

34701 **Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 824

2021 Work RVU: 23.71
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.98

RUC Recommendation: 23.71 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34702 **Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 99

2021 Work RVU: 36.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.51

RUC Recommendation: 36.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34703 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,118

2021 Work RVU: 26.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.34

RUC Recommendation: 26.52 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34704 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 141

2021 Work RVU: 45.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.18

RUC Recommendation: 45.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34705 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 13,089

2021 Work RVU: 29.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.07

RUC Recommendation: 29.58 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34706 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 641

2021 Work RVU: 45.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.45

RUC Recommendation: 45.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34707 **Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 652

2021 Work RVU: 22.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.55

RUC Recommendation: 22.28 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34708 **Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 85

2021 Work RVU: 36.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 36.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34709 **Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 3,632

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 6.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34710 **Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,186

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.80

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34711 **Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; each additional vessel treated (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 367

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.26

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34712 **Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,214

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.47

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34713 **Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 16,159

2021 Work RVU: 2.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.53

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34714 **Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 487

2021 Work RVU: 5.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34715 **Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 206

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.32

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34716 **Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 798

2021 Work RVU: 7.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.00

RUC Recommendation: 7.19 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34800 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34802 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis / Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34803 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34804 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34805 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34806 **Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34812 **Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 9,013

2021 Work RVU: 4.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.90

RUC Recommendation: 4.13 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34820 **Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 82

2021 Work RVU: 7.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.44

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34825 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis / Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34826 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34833 **Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 46

2021 Work RVU: 8.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.29

RUC Recommendation: 8.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34834 **Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 366

2021 Work RVU: 2.65
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.48

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34900 **Endovascular repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using ilio-iliac tube endoprosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35301 **Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision**

Global: 090 **Issue:** Thromboendarterectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 21 **Specialty Developing Recommendation:** SVS **First Identified:** September 2011 **2019 est Medicare Utilization:** 35,904

2021 Work RVU: 21.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.69

RUC Recommendation: 21.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

35450 **Transluminal balloon angioplasty, open; renal or other visceral artery**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35452 **Transluminal balloon angioplasty, open; aortic**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35454 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35456 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35458 **Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35459 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35460 **Transluminal balloon angioplasty, open; venous**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35470 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35471 **Transluminal balloon angioplasty, percutaneous; renal or visceral artery**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35472 **Transluminal balloon angioplasty, percutaneous; aortic**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Removed from CPT referral **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35473 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35474 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35475 **Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35476 **Transluminal balloon angioplasty, percutaneous; venous**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35490 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35491 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35492 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35493 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35494 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35495 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35701 **Exploration not followed by surgical repair, artery; neck (eg, carotid, subclavian)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 823

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.08

RUC Recommendation: 7.50 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35702 **Exploration not followed by surgical repair, artery; upper extremity (eg, axillary, brachial, radial, ulnar)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.38

RUC Recommendation: 7.12 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35703 **Exploration not followed by surgical repair, artery; lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.00

RUC Recommendation: 7.50 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35721 **Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery** **Global:** **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 484

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35741 **Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery**

Global: **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 199

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35761 **Exploration (not followed by surgical repair), with or without lysis of artery; other vessels**

Global: **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** April 2017 **2019 est Medicare Utilization:** 1,616

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36000 **Introduction of needle or intracatheter, vein**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, AUR, AAP, AAFP, ACRh **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.07

RUC Recommendation: CMS consider a bundled status for this code **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36010 **Introduction of catheter, superior or inferior vena cava**

Global: XXX **Issue:** Introduction of Catheter **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,377

2021 Work RVU: 2.18
2021 NF PE RVU: 14.12
2021 Fac PE RVU: 0.62

RUC Recommendation: Remove from re-review. **Referred to CPT** February 2011 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

36140 **Introduction of needle or intracatheter, upper or lower extremity artery**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACRO **First Identified:** April 2011 **2019 est Medicare Utilization:** 20,331

2021 Work RVU: 1.76
2021 NF PE RVU: 13.35
2021 Fac PE RVU: 0.49

RUC Recommendation: Remove from re-review **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

36145 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 9 **Specialty Developing Recommendation:** **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36147 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36148 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization greater than 30,000-Part2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 45,269

2021 Work RVU: 4.17
2021 NF PE RVU: 28.04
2021 Fac PE RVU: 1.44

RUC Recommendation: 4.17 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36216 **Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,580

2021 Work RVU: 5.27
2021 NF PE RVU: 27.97
2021 Fac PE RVU: 1.66

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36217 **Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 4,059

2021 Work RVU: 6.29
2021 NF PE RVU: 49.17
2021 Fac PE RVU: 1.98

RUC Recommendation: 6.29 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36218 **Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Selective Catheter Placement **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 1.01
2021 NF PE RVU: 5.35
2021 Fac PE RVU: 0.30

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36221 **Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,095

2021 Work RVU: 3.92
2021 NF PE RVU: 27.05
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.51 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36222 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 7,752

2021 Work RVU: 5.28
2021 NF PE RVU: 31.56
2021 Fac PE RVU: 1.77

RUC Recommendation: 6.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36223 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 29,312

2021 Work RVU: 5.75
2021 NF PE RVU: 42.78
2021 Fac PE RVU: 2.20

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36224 **Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 36,594

2021 Work RVU: 6.25
2021 NF PE RVU: 55.63
2021 Fac PE RVU: 2.68

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36225 **Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,267

2021 Work RVU: 5.75
2021 NF PE RVU: 40.17
2021 Fac PE RVU: 2.13

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36226 **Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 32,221

2021 Work RVU: 6.25
2021 NF PE RVU: 52.87
2021 Fac PE RVU: 2.61

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36227 **Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 13,979

2021 Work RVU: 2.09
2021 NF PE RVU: 4.66
2021 Fac PE RVU: 0.83

RUC Recommendation: 2.32 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36228 **Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,336

2021 Work RVU: 4.25
2021 NF PE RVU: 34.39
2021 Fac PE RVU: 1.71

RUC Recommendation: 4.25 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36245 **Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: XXX **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 22 **Specialty Developing Recommendation:** ACC, ACR, SIR, SCAI, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:** 40,259

2021 Work RVU: 4.65
2021 NF PE RVU: 34.72
2021 Fac PE RVU: 1.43

RUC Recommendation: 4.90 **Referred to CPT** February 2010 and February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36246 **Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 36,476

2021 Work RVU: 5.02
2021 NF PE RVU: 20.12
2021 Fac PE RVU: 1.35

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36247 **Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 66,061

2021 Work RVU: 6.04
2021 NF PE RVU: 38.48
2021 Fac PE RVU: 1.65

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

36248 **Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Catheter Placement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 26,334

2021 Work RVU: 1.01
2021 NF PE RVU: 2.71
2021 Fac PE RVU: 0.28

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36251 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 3,603

2021 Work RVU: 5.10
2021 NF PE RVU: 35.66
2021 Fac PE RVU: 1.51

RUC Recommendation: 5.45 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36252 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 8,044

2021 Work RVU: 6.74
2021 NF PE RVU: 36.70
2021 Fac PE RVU: 2.26

RUC Recommendation: 7.38 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36253 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 1,646

2021 Work RVU: 7.30
2021 NF PE RVU: 57.15
2021 Fac PE RVU: 2.15

RUC Recommendation: 7.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36254 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 162

2021 Work RVU: 7.90
2021 NF PE RVU: 54.59
2021 Fac PE RVU: 2.47

RUC Recommendation: 8.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36410 **Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)**

Global: XXX **Issue:** Venipunture **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 36 **Specialty Developing Recommendation:** ACP **First Identified:** October 2009 **2019 est Medicare Utilization:** 155,240

2021 Work RVU: 0.18
2021 NF PE RVU: 0.31
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36475 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated**

Global: 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 109,583

2021 Work RVU: 5.30
2021 NF PE RVU: 31.36
2021 Fac PE RVU: 1.73

RUC Recommendation: 5.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36476 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** October 2013 **2019 est Medicare Utilization:** 7,170

2021 Work RVU: 2.65
2021 NF PE RVU: 5.77
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36478 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated**

Global: 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,677

2021 Work RVU: 5.30
2021 NF PE RVU: 25.42
2021 Fac PE RVU: 1.76

RUC Recommendation: 5.30 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36479 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,461

2021 Work RVU: 2.65
2021 NF PE RVU: 6.26
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36481 **Percutaneous portal vein catheterization by any method**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 697

2021 Work RVU: 6.73
2021 NF PE RVU: 49.03
2021 Fac PE RVU: 2.06

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

36511 **Therapeutic apheresis; for white blood cells**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 235

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.06

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36512 **Therapeutic apheresis; for red blood cells**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 2,896

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36513 **Therapeutic apheresis; for platelets**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 192

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.94

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

Status Report: CMS Requests and Relativity Assessment Issues

36514 **Therapeutic apheresis; for plasma pheresis**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 28,894

2021 Work RVU: 1.81
2021 NF PE RVU: 17.01
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.81. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36515 **Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion**

Global: **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36516 **Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,069

2021 Work RVU: 1.56
2021 NF PE RVU: 56.69
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.56. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

Status Report: CMS Requests and Relativity Assessment Issues

36522 **Photopheresis, extracorporeal** **Global:** 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 8,303

2021 Work RVU: 1.75
2021 NF PE RVU: 48.78
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.75. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36555 **Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age** **Global:** 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 26

2021 Work RVU: 1.93
2021 NF PE RVU: 3.70
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.93 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36556 **Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older** **Global:** 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 409,595

2021 Work RVU: 1.75
2021 NF PE RVU: 4.60
2021 Fac PE RVU: 0.50

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36568 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age**

Global: 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2016 **2019 est Medicare Utilization:** 3

2021 Work RVU: 2.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.34

RUC Recommendation: 2.11 **Referred to CPT** September 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36569 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** July 2015 **2019 est Medicare Utilization:** 14,961

2021 Work RVU: 1.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.90. Review at RAW in October 2021. **Referred to CPT** September 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36572 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 25

2021 Work RVU: 1.82
2021 NF PE RVU: 11.35
2021 Fac PE RVU: 0.65

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36573 **Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:**

First Identified: September 2017 **2019 est Medicare Utilization:** 88,728

2021 Work RVU: 1.70
2021 NF PE RVU: 10.27
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36584 **Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement**

Global: 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2016 **2019 est Medicare Utilization:** 4,270

2021 Work RVU: 1.20
2021 NF PE RVU: 9.21
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.47 **Referred to CPT** September 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36620 **Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ASA

First Identified: July 2015 **2019 est Medicare Utilization:** 581,132

2021 Work RVU: 1.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.20

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36818 **Arteriovenous anastomosis, open; by upper arm cephalic vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 5,179

2021 Work RVU: 12.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.81

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

36819 **Arteriovenous anastomosis, open; by upper arm basilic vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 7,456

2021 Work RVU: 13.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.87

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

36820 **Arteriovenous anastomosis, open; by forearm vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,343

2021 Work RVU: 13.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.90

RUC Recommendation: 13.99 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36821 **Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 30,775

2021 Work RVU: 11.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.61

RUC Recommendation: 11.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36822 **Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** February 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36825 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,949

2021 Work RVU: 14.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.66

RUC Recommendation: 15.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36830 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 20,101

2021 Work RVU: 12.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.56

RUC Recommendation: 11.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36834 **Deleted from CPT**

Global: **Issue:** Aneurysm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AVA, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36870 **Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36901 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 68,183

2021 Work RVU: 3.36
2021 NF PE RVU: 17.84
2021 Fac PE RVU: 1.05

RUC Recommendation: 3.36 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36902 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 199,617

2021 Work RVU: 4.83
2021 NF PE RVU: 33.47
2021 Fac PE RVU: 1.47

RUC Recommendation: 4.83 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36903 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 20,847

2021 Work RVU: 6.39
2021 NF PE RVU: 140.30
2021 Fac PE RVU: 1.82

RUC Recommendation: 6.39 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36904 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,595

2021 Work RVU: 7.50
2021 NF PE RVU: 48.72
2021 Fac PE RVU: 2.16

RUC Recommendation: 7.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36905 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 41,205

2021 Work RVU: 9.00
2021 NF PE RVU: 63.02
2021 Fac PE RVU: 2.73

RUC Recommendation: 9.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36906 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 14,028

2021 Work RVU: 10.42
2021 NF PE RVU: 173.18
2021 Fac PE RVU: 3.02

RUC Recommendation: 10.42 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36907 **Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 67,888

2021 Work RVU: 3.00
2021 NF PE RVU: 16.34
2021 Fac PE RVU: 0.83

RUC Recommendation: 3.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36908 **Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,376

2021 Work RVU: 4.25
2021 NF PE RVU: 49.50
2021 Fac PE RVU: 1.13

RUC Recommendation: 4.25 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36909 **Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,424

2021 Work RVU: 4.12
2021 NF PE RVU: 57.02
2021 Fac PE RVU: 1.11

RUC Recommendation: 4.12 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37183 **Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recannulization/dilatation, stent placement and all associated imaging guidance and documentation)**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 893

2021 Work RVU: 7.74
2021 NF PE RVU: 180.49
2021 Fac PE RVU: 2.36

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37191 **Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 25,555

2021 Work RVU: 4.46
2021 NF PE RVU: 63.97
2021 Fac PE RVU: 1.38

RUC Recommendation: 4.71 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37192 **Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 32

2021 Work RVU: 7.10
2021 NF PE RVU: 31.60
2021 Fac PE RVU: 1.20

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37193 **Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 7,478

2021 Work RVU: 7.10
2021 NF PE RVU: 39.56
2021 Fac PE RVU: 2.01

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37201 **Transcatheter therapy, infusion for thrombolysis other than coronary**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37203 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)**

Global: **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37204 **Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck**

Global: **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37205 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37206 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37207 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37208 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37209 **Exchange of a previously placed intravascular catheter during thrombolytic therapy**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37210 **Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure**

Global: **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37211 **Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,642

2021 Work RVU: 7.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37212 **Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,012

2021 Work RVU: 6.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.89

RUC Recommendation: 7.06 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37213 **Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,217

2021 Work RVU: 4.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37214 **Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,963

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.66

RUC Recommendation: 3.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37220 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 12,377

2021 Work RVU: 7.90
2021 NF PE RVU: 74.19
2021 Fac PE RVU: 2.01

RUC Recommendation: Refer to CPT. 8.15 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37221 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 35,798

2021 Work RVU: 9.75
2021 NF PE RVU: 96.83
2021 Fac PE RVU: 2.50

RUC Recommendation: Refer to CPT. 10.00 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37222 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,550

2021 Work RVU: 3.73
2021 NF PE RVU: 16.14
2021 Fac PE RVU: 0.84

RUC Recommendation: Refer to CPT. 3.73 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37223 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,293

2021 Work RVU: 4.25
2021 NF PE RVU: 44.04
2021 Fac PE RVU: 1.00

RUC Recommendation: Refer to CPT. 4.25 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37224 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 34,142

2021 Work RVU: 8.75
2021 NF PE RVU: 88.47
2021 Fac PE RVU: 2.29

RUC Recommendation: Refer to CPT. 9.00 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37225 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 45,496

2021 Work RVU: 11.75
2021 NF PE RVU: 299.74
2021 Fac PE RVU: 3.24

RUC Recommendation: Refer to CPT. **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37226 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 24,981

2021 Work RVU: 10.24
2021 NF PE RVU: 273.20
2021 Fac PE RVU: 2.63

RUC Recommendation: Refer to CPT. 10.49 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37227 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 23,176

2021 Work RVU: 14.25
2021 NF PE RVU: 385.21
2021 Fac PE RVU: 3.70

RUC Recommendation: Refer to CPT. 14.50 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37228 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 34,531

2021 Work RVU: 10.75
2021 NF PE RVU: 128.91
2021 Fac PE RVU: 2.71

RUC Recommendation: Refer to CPT. 11.00 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37229 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 39,373

2021 Work RVU: 13.80
2021 NF PE RVU: 299.25
2021 Fac PE RVU: 3.68

RUC Recommendation: Refer to CPT. 14.05 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37230 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,808

2021 Work RVU: 13.55
2021 NF PE RVU: 284.04
2021 Fac PE RVU: 3.81

RUC Recommendation: Refer to CPT. 13.80 **Referred to CPT** September 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37231 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,320

2021 Work RVU: 14.75
2021 NF PE RVU: 386.13
2021 Fac PE RVU: 4.12

RUC Recommendation: Refer to CPT. 15.00 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37232 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,835

2021 Work RVU: 4.00
2021 NF PE RVU: 23.55
2021 Fac PE RVU: 1.01

RUC Recommendation: Refer to CPT. 4.00 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37233 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,241

2021 Work RVU: 6.50
2021 NF PE RVU: 27.13
2021 Fac PE RVU: 1.62

RUC Recommendation: Refer to CPT. 6.50 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37234 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 343

2021 Work RVU: 5.50
2021 NF PE RVU: 111.73
2021 Fac PE RVU: 1.62

RUC Recommendation: Refer to CPT. 5.50 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37235 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 100

2021 Work RVU: 7.80
2021 NF PE RVU: 116.61
2021 Fac PE RVU: 2.24

RUC Recommendation: Refer to CPT. 7.80 **Referred to CPT** September 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37236 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery**

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 13,074

2021 Work RVU: 8.75
2021 NF PE RVU: 84.52
2021 Fac PE RVU: 2.32

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37237 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 1,497

2021 Work RVU: 4.25
2021 NF PE RVU: 43.32
2021 Fac PE RVU: 0.98

RUC Recommendation: 4.25 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37238 **Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein**

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 10,579

2021 Work RVU: 6.04
2021 NF PE RVU: 106.77
2021 Fac PE RVU: 1.72

RUC Recommendation: 6.29 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37239 **Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 4,688

2021 Work RVU: 2.97
2021 NF PE RVU: 53.45
2021 Fac PE RVU: 0.83

RUC Recommendation: 3.34 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37241 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,922

2021 Work RVU: 8.75
2021 NF PE RVU: 137.81
2021 Fac PE RVU: 2.50

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 8,635

2021 Work RVU: 9.80
2021 NF PE RVU: 220.06
2021 Fac PE RVU: 2.58

RUC Recommendation: 11.98 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,067

2021 Work RVU: 11.74
2021 NF PE RVU: 271.90
2021 Fac PE RVU: 3.36

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 12,731

2021 Work RVU: 13.75
2021 NF PE RVU: 198.34
2021 Fac PE RVU: 4.14

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37246 **Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery**

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 8,680

2021 Work RVU: 7.00
2021 NF PE RVU: 51.34
2021 Fac PE RVU: 1.87

RUC Recommendation: 7.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37247 **Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 760

2021 Work RVU: 3.50
2021 NF PE RVU: 14.34
2021 Fac PE RVU: 0.73

RUC Recommendation: 3.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37248 **Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein**

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 15,577

2021 Work RVU: 6.00
2021 NF PE RVU: 37.31
2021 Fac PE RVU: 1.79

RUC Recommendation: 6.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37249 **Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 3,865

2021 Work RVU: 2.97
2021 NF PE RVU: 11.33
2021 Fac PE RVU: 0.76

RUC Recommendation: 2.97 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37250 **Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37251 **Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37252 **Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:** 60,377

2021 Work RVU: 1.80
2021 NF PE RVU: 30.84
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.80 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37253 **Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:** 91,408

2021 Work RVU: 1.44
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.44 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37609 **Ligation or biopsy, temporal artery**

Global: 010 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** SVS, ACS

First Identified: September 2007 **2019 est Medicare Utilization:** 14,539

2021 Work RVU: 3.05
2021 NF PE RVU: 5.75
2021 Fac PE RVU: 2.33

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

37619 **Ligation of inferior vena cava**

Global: 090 **Issue:** Ligation of Inferior Vena Cava **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACS, SVS

First Identified: February 2011 **2019 est Medicare Utilization:** 33

2021 Work RVU: 30.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.67

RUC Recommendation: 37.60

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

37620 **Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)**

Global: **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS

First Identified: February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

37760 **Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg**

Global: 090 **Issue:** Perorator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 65

2021 Work RVU: 10.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.01

RUC Recommendation: 10.69 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

37761 **Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg**

Global: 090 **Issue:** Perforator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** April 2009 **2019 est Medicare Utilization:** 350

2021 Work RVU: 9.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.43

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

37765 **Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions**

Global: 010 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:** 14,709

2021 Work RVU: 4.80
2021 NF PE RVU: 7.22
2021 Fac PE RVU: 2.08

RUC Recommendation: 4.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37766 **Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions**

Global: 010 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:** 11,253

2021 Work RVU: 6.00
2021 NF PE RVU: 7.92
2021 Fac PE RVU: 2.42

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37785 **Ligation, division, and/or excision of varicose vein cluster(s), 1 leg** **Global:** 090 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, SVS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 934

2021 Work RVU: 3.93
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 2.69

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

38220 **Diagnostic bone marrow; aspiration(s)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2019 est Medicare Utilization:** 7,044

2021 Work RVU: 1.20
2021 NF PE RVU: 3.57
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.20 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38221 **Diagnostic bone marrow; biopsy(ies)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** July 2015 **2019 est Medicare Utilization:** 12,465

2021 Work RVU: 1.28
2021 NF PE RVU: 3.37
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.28 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38222 **Diagnostic bone marrow; biopsy(ies) and aspiration(s)** **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2019 est Medicare Utilization:** 120,998

2021 Work RVU: 1.44
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 0.69

RUC Recommendation: 1.44 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

38505 **Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)**

Global: 000 **Issue:** Needle Biopsy of Lymph Nodes **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2019 **2019 est Medicare Utilization:** 33,584

2021 Work RVU: 1.14
2021 NF PE RVU: 2.36
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.59 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

38542 **Dissection, deep jugular node(s)**

Global: 090 **Issue:** Jugular Node Dissection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 40 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 571

2021 Work RVU: 7.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.90

RUC Recommendation: 7.85 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

38570 **Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** AUA **First Identified:** January 2014 **2019 est Medicare Utilization:** 5,714

2021 Work RVU: 8.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.18

RUC Recommendation: 9.34 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

38571 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** CMS Fastest Growing / 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2019 est Medicare Utilization:** 17,981

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.87

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38572 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** ACOG **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,251

2021 Work RVU: 15.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.67

RUC Recommendation: 15.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38792 **Injection procedure; radioactive tracer for identification of sentinel node**

Global: 000 **Issue:** Radioactive Tracer **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 23 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 33,143

2021 Work RVU: 0.65
2021 NF PE RVU: 1.72
2021 Fac PE RVU: 0.23

RUC Recommendation: 0.65 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

39400 **Mediastinoscopy, includes biopsy(ies), when performed**

Global: **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

39401 **Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed**

Global: 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** October 2014 **2019 est Medicare Utilization:** 535

2021 Work RVU: 5.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.30

RUC Recommendation: 5.44 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

39402 **Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)**

Global: 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,086

2021 Work RVU: 7.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.87

RUC Recommendation: 7.50 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

40490 **Biopsy of lip**

Global: 000 **Issue:** Biopsy of Lip **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 21 **Specialty Developing Recommendation:** AAO-HNS, AAD **First Identified:** April 2011 **2019 est Medicare Utilization:** 32,762

2021 Work RVU: 1.22
2021 NF PE RVU: 2.34
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

40650 **Repair lip, full thickness; vermilion only**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 355

2021 Work RVU: 3.78
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 4.60

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2016

Status Report: CMS Requests and Relativity Assessment Issues

40800 **Drainage of abscess, cyst, hematoma, vestibule of mouth; simple** **Global:** 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,390

2021 Work RVU: 1.23
2021 NF PE RVU: 4.87
2021 Fac PE RVU: 2.19

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

40801 **Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated** **Global:** 010 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,609

2021 Work RVU: 2.63
2021 NF PE RVU: 5.88
2021 Fac PE RVU: 2.97

RUC Recommendation: Maintain. Reduced 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

40808 **Biopsy, vestibule of mouth** **Global:** 010 **Issue:** Biopsy of Mouth Lesion **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAOHNS, AAOMS **First Identified:** April 2017 **2019 est Medicare Utilization:** 10,517

2021 Work RVU: 1.05
2021 NF PE RVU: 3.81
2021 Fac PE RVU: 1.36

RUC Recommendation: 1.05 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

40812 **Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 5,703

2021 Work RVU: 2.37
2021 NF PE RVU: 5.96
2021 Fac PE RVU: 2.85

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

40820 **Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,264

2021 Work RVU: 1.34
2021 NF PE RVU: 6.47
2021 Fac PE RVU: 3.54

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

41530 **Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session**

Global: 000 **Issue:** Submucosal ablation of tongue base **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 26 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** July 2014 **2019 est Medicare Utilization:** 350

2021 Work RVU: 3.50
2021 NF PE RVU: 25.25
2021 Fac PE RVU: 7.42

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

42145 **Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)**

Global: 090 **Issue:** Palatopharyngoplasty **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 41 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 518

2021 Work RVU: 9.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.13

RUC Recommendation: 9.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

42415 **Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,439

2021 Work RVU: 17.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.16

RUC Recommendation: 18.12 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42420 **Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,561

2021 Work RVU: 19.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.21

RUC Recommendation: 21.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42440 **Excision of submandibular (submaxillary) gland**

Global: 090 **Issue:** Submandibular Gland Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 64 **Specialty Developing Recommendation:** AAO-HNS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,780

2021 Work RVU: 6.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.06

RUC Recommendation: 7.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,988

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.65

RUC Recommendation: 2.78 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 211

2021 Work RVU: 2.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.21 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 210

2021 Work RVU: 2.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43194 **Esophagoscopy, rigid, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 115

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 3.99 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43195 **Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 569

2021 Work RVU: 3.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.21 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43196 **Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 486

2021 Work RVU: 3.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.94

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

43197 **Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES, AGA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,136

2021 Work RVU: 1.52
2021 NF PE RVU: 4.07
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43198 **Esophagoscopy, flexible, transnasal; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES, AGA **First Identified:** September 2011 **2019 est Medicare Utilization:** 255

2021 Work RVU: 1.82
2021 NF PE RVU: 4.32
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.89 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43200 **Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,390

2021 Work RVU: 1.42
2021 NF PE RVU: 6.21
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.59 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43201 **Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 220

2021 Work RVU: 1.72
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 1.04

RUC Recommendation: 1.90 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43202 **Esophagoscopy, flexible, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,578

2021 Work RVU: 1.72
2021 NF PE RVU: 8.94
2021 Fac PE RVU: 1.05

RUC Recommendation: 1.89 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43204 **Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 13

2021 Work RVU: 2.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 2.89 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43205 **Esophagoscopy, flexible, transoral; with band ligation of esophageal varices**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 159

2021 Work RVU: 2.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 3.00 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43206 **Esophagoscopy, flexible, transoral; with optical endomicroscopy** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 21

2021 Work RVU: 2.29
2021 NF PE RVU: 6.52
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43211 **Esophagoscopy, flexible, transoral; with endoscopic mucosal resection** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 99

2021 Work RVU: 4.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.17

RUC Recommendation: 4.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43212 **Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 585

2021 Work RVU: 3.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.57

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43213 **Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 187

2021 Work RVU: 4.63
2021 NF PE RVU: 33.35
2021 Fac PE RVU: 2.24

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43214 **Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 215

2021 Work RVU: 3.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.78

RUC Recommendation: 3.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43215 **Esophagoscopy, flexible, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 989

2021 Work RVU: 2.44
2021 NF PE RVU: 9.30
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.60 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43216 **Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 195

2021 Work RVU: 2.30
2021 NF PE RVU: 10.01
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.40 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43217 **Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 53

2021 Work RVU: 2.80
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 1.56

RUC Recommendation: 2.90 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43219 **Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent** **Global:** **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43220 **Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,069

2021 Work RVU: 2.00
2021 NF PE RVU: 27.96
2021 Fac PE RVU: 1.18

RUC Recommendation: 2.10 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43226 **Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,841

2021 Work RVU: 2.24
2021 NF PE RVU: 8.98
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.34 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43227 **Esophagoscopy, flexible, transoral; with control of bleeding, any method** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 191

2021 Work RVU: 2.89
2021 NF PE RVU: 15.89
2021 Fac PE RVU: 1.58

RUC Recommendation: 3.26 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43228 **Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43229 **Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,331

2021 Work RVU: 3.49
2021 NF PE RVU: 18.25
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.72 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43231 **Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 502

2021 Work RVU: 2.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 3.19 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43232 **Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 435

2021 Work RVU: 3.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.83 **Referred to CPT** May 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43233 **Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,577

2021 Work RVU: 4.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.03

RUC Recommendation: 4.45 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43234 **Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)**

Global: **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** EGD **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 323,621

2021 Work RVU: 2.09
2021 NF PE RVU: 6.59
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.26 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2008 **2019 est Medicare Utilization:** 16,281

2021 Work RVU: 2.39
2021 NF PE RVU: 9.43
2021 Fac PE RVU: 1.37

RUC Recommendation: 2.57 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2009 and Jun 2010

43237 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 18,922

2021 Work RVU: 3.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.85

RUC Recommendation: 3.85 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43238 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 14,141

2021 Work RVU: 4.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.15

RUC Recommendation: 4.50 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43239 **Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** EGD with Biopsy **Screen:** MPC List / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,424,058

2021 Work RVU: 2.39
2021 NF PE RVU: 8.84
2021 Fac PE RVU: 1.37

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43240 **Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,002

2021 Work RVU: 7.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.48

RUC Recommendation: 7.25 **Referred to CPT** February 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43241 **Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,312

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.36

RUC Recommendation: 2.59 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43242 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2019 est Medicare Utilization:** 26,340

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.39 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43243 **Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 647

2021 Work RVU: 4.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.14

RUC Recommendation: 4.37 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43244 **Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 22,233

2021 Work RVU: 4.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.26

RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43245 **Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 15,047

2021 Work RVU: 3.08
2021 NF PE RVU: 15.04
2021 Fac PE RVU: 1.64

RUC Recommendation: 3.18 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43246 **Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 71,081

2021 Work RVU: 3.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.78

RUC Recommendation: 4.32 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43247 **Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 28,637

2021 Work RVU: 3.11
2021 NF PE RVU: 8.12
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.27 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43248 **Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 110,879

2021 Work RVU: 2.91
2021 NF PE RVU: 9.18
2021 Fac PE RVU: 1.60

RUC Recommendation: 3.01 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43249 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 125,878

2021 Work RVU: 2.67
2021 NF PE RVU: 31.47
2021 Fac PE RVU: 1.49

RUC Recommendation: 2.77 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43250 **Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,775

2021 Work RVU: 2.97
2021 NF PE RVU: 10.44
2021 Fac PE RVU: 1.58

RUC Recommendation: 3.07 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43251 **Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 35,888

2021 Work RVU: 3.47
2021 NF PE RVU: 11.28
2021 Fac PE RVU: 1.84

RUC Recommendation: 3.57 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43253 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** February 2012 **2019 est Medicare Utilization:** 2,309

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.39 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43254 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,797

2021 Work RVU: 4.87
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.46

RUC Recommendation: 5.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 62,091

2021 Work RVU: 3.56
2021 NF PE RVU: 16.12
2021 Fac PE RVU: 1.88

RUC Recommendation: 4.20 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43256 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43257 **Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 148

2021 Work RVU: 4.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.11

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43258 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43259 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2019 est Medicare Utilization:** 34,294

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 4.74 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43260 **Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,795

2021 Work RVU: 5.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.90

RUC Recommendation: 5.95 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 7,154

2021 Work RVU: 6.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.04

RUC Recommendation: 6.25 **Referred to CPT** January 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 30,450

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.19

RUC Recommendation: 6.60 **Referred to CPT** January 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 67

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 7.28 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43264 **Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:** 56,121

2021 Work RVU: 6.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.25

RUC Recommendation: 6.73 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43265 **Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,820

2021 Work RVU: 7.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.83

RUC Recommendation: 8.03 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43266 **Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,767

2021 Work RVU: 3.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.93

RUC Recommendation: 4.40 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43267 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43268 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct**

Global: **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43269 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43270 **Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 20,628

2021 Work RVU: 4.01
2021 NF PE RVU: 18.21
2021 Fac PE RVU: 2.08

RUC Recommendation: 4.39 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43271 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43272 **Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43273 **Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)**

Global: ZZZ **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 8,668

2021 Work RVU: 2.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.24 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 43,064

2021 Work RVU: 8.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.07

RUC Recommendation: 8.74 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43275 **Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 14,287

2021 Work RVU: 6.86
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.35

RUC Recommendation: 6.96 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 16,434

2021 Work RVU: 8.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.24

RUC Recommendation: 9.10 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 6,694

2021 Work RVU: 6.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.37

RUC Recommendation: 7.11 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 600

2021 Work RVU: 7.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.81

RUC Recommendation: 8.08 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43450 **Dilation of esophagus, by unguided sound or bougie, single or multiple passes**

Global: 000 **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 71,670

2021 Work RVU: 1.28
2021 NF PE RVU: 4.18
2021 Fac PE RVU: 0.88

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43453 **Dilation of esophagus, over guide wire**

Global: 000 **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,698

2021 Work RVU: 1.41
2021 NF PE RVU: 25.10
2021 Fac PE RVU: 0.93

RUC Recommendation: 1.51 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43456 **Dilation of esophagus, by balloon or dilator, retrograde** **Global:** **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43458 **Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia** **Global:** **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43760 **Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance** **Global:** **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** July 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43762 **Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract** **Global:** 000 **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2019 est Medicare Utilization:** 49,049

2021 Work RVU: 0.75
2021 NF PE RVU: 6.23
2021 Fac PE RVU: 0.23

RUC Recommendation: 0.75. Flag for Re-review. **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43763 **Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract**

Global: 000 **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 1.41
2021 NF PE RVU: 9.02
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.41. Flag for Re-review.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44143 **Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)**

Global: 090 **Issue:** RAW **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** **First Identified:** October 2015 **2019 est Medicare Utilization:** 10,216

2021 Work RVU: 27.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.94

RUC Recommendation: 99214 visit appropriate. Remove from screen.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

44205 **Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,383

2021 Work RVU: 22.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.62

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

44207 **Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 9,951

2021 Work RVU: 31.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.07

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

44380 **Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,038

2021 Work RVU: 0.87
2021 NF PE RVU: 4.95
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44381 **Ileoscopy, through stoma; with transendoscopic balloon dilation**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2019 est Medicare Utilization:** 150

2021 Work RVU: 1.38
2021 NF PE RVU: 29.46
2021 Fac PE RVU: 0.88

RUC Recommendation: 1.48 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44382 **Ileoscopy, through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Ileoscopy Ileoscopy Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,549

2021 Work RVU: 1.17
2021 NF PE RVU: 7.87
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.27 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44383 **Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44384 **Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2019 est Medicare Utilization:** 124

2021 Work RVU: 2.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.30

RUC Recommendation: 3.11 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44385 **Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 05 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,312

2021 Work RVU: 1.20
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.30 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44386 **Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple**

Global: 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 05 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,832

2021 Work RVU: 1.50
2021 NF PE RVU: 7.87
2021 Fac PE RVU: 0.91

RUC Recommendation: 1.60 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44388 **Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,180

2021 Work RVU: 2.72
2021 NF PE RVU: 6.39
2021 Fac PE RVU: 1.45

RUC Recommendation: 2.82 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

44389 **Colonoscopy through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,551

2021 Work RVU: 3.02
2021 NF PE RVU: 9.13
2021 Fac PE RVU: 1.61

RUC Recommendation: 3.12 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

44390 **Colonoscopy through stoma; with removal of foreign body(s)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 18

2021 Work RVU: 3.74
2021 NF PE RVU: 8.05
2021 Fac PE RVU: 1.97

RUC Recommendation: 3.82 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

44391 **Colonoscopy through stoma; with control of bleeding, any method**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 159

2021 Work RVU: 4.12
2021 NF PE RVU: 15.88
2021 Fac PE RVU: 2.12

RUC Recommendation: 4.22 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44392 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 297

2021 Work RVU: 3.53
2021 NF PE RVU: 7.58
2021 Fac PE RVU: 1.76

RUC Recommendation: 3.63 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44393 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44394 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,081

2021 Work RVU: 4.03
2021 NF PE RVU: 8.72
2021 Fac PE RVU: 2.03

RUC Recommendation: 4.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44397 **Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44401 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 65

2021 Work RVU: 4.34
2021 NF PE RVU: 77.43
2021 Fac PE RVU: 2.24

RUC Recommendation: 4.44 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44402 **Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 4

2021 Work RVU: 4.70
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.40

RUC Recommendation: 4.96 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44403 **Colonoscopy through stoma; with endoscopic mucosal resection**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 76

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.75

RUC Recommendation: 5.81 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44404 **Colonoscopy through stoma; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 190

2021 Work RVU: 3.02
2021 NF PE RVU: 9.22
2021 Fac PE RVU: 1.61

RUC Recommendation: 3.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44405 **Colonoscopy through stoma; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 57

2021 Work RVU: 3.23
2021 NF PE RVU: 13.75
2021 Fac PE RVU: 1.75

RUC Recommendation: 3.33 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44406 **Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 4

2021 Work RVU: 4.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.13

RUC Recommendation: 4.41 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44407 **Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 4.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.51

RUC Recommendation: 5.06 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44408 **Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 76

2021 Work RVU: 4.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.15

RUC Recommendation: 4.24 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44901 **Incision and drainage of appendiceal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44970 **Laparoscopy, surgical, appendectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS **First Identified:** October 2008 **2019 est Medicare Utilization:** 22,448

2021 Work RVU: 9.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.13

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

45170 **Deleted from CPT**

Global: **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45171 **Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)**

Global: 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,516

2021 Work RVU: 8.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.72

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45172 **Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)**

Global: 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,918

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.18

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45300 **Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Diagnostic Proctosigmoidoscopy - Rigid **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACS, ASCRS, SAGES **First Identified:** July 2016 **2019 est Medicare Utilization:** 23,267

2021 Work RVU: 0.80
2021 NF PE RVU: 2.99
2021 Fac PE RVU: 0.48

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45330 **Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:** 50,795

2021 Work RVU: 0.84
2021 NF PE RVU: 4.65
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.84 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45331 **Sigmoidoscopy, flexible; with biopsy, single or multiple**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 36,318

2021 Work RVU: 1.14
2021 NF PE RVU: 7.50
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.14 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45332 **Sigmoidoscopy, flexible; with removal of foreign body(s)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 353

2021 Work RVU: 1.76
2021 NF PE RVU: 6.40
2021 Fac PE RVU: 1.07

RUC Recommendation: 1.85 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45333 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 734

2021 Work RVU: 1.55
2021 NF PE RVU: 8.32
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.65 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45334 **Sigmoidoscopy, flexible; with control of bleeding, any method** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,411

2021 Work RVU: 2.00
2021 NF PE RVU: 13.83
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.10 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45335 **Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,141

2021 Work RVU: 1.04
2021 NF PE RVU: 7.61
2021 Fac PE RVU: 0.76

RUC Recommendation: 1.15 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45337 **Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,691

2021 Work RVU: 2.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.20 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45338 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,383

2021 Work RVU: 2.05
2021 NF PE RVU: 6.77
2021 Fac PE RVU: 1.20

RUC Recommendation: 2.15 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45339 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45340 **Sigmoidoscopy, flexible; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,316

2021 Work RVU: 1.25
2021 NF PE RVU: 12.98
2021 Fac PE RVU: 0.85

RUC Recommendation: 1.35 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45341 **Sigmoidoscopy, flexible; with endoscopic ultrasound examination** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,713

2021 Work RVU: 2.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 2.43 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

45342 **Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 374

2021 Work RVU: 2.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.64

RUC Recommendation: 3.08 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45345 **Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45346 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** May 2013 **2019 est Medicare Utilization:** 1,183

2021 Work RVU: 2.81
2021 NF PE RVU: 76.84
2021 Fac PE RVU: 1.54

RUC Recommendation: 2.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45347 **Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** May 2013 **2019 est Medicare Utilization:** 637

2021 Work RVU: 2.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.47

RUC Recommendation: 2.98 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45349 **Sigmoidoscopy, flexible; with endoscopic mucosal resection**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 632

2021 Work RVU: 3.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.86

RUC Recommendation: 3.83 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45350 **Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,214

2021 Work RVU: 1.68
2021 NF PE RVU: 18.66
2021 Fac PE RVU: 1.04

RUC Recommendation: 1.78 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45355 **Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple** **Global:** **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45378 **Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS High Expenditure Procedural Codes1 / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 345,987

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45379 **Colonoscopy, flexible; with removal of foreign body(s)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 930

2021 Work RVU: 4.28
2021 NF PE RVU: 8.32
2021 Fac PE RVU: 2.17

RUC Recommendation: 4.37 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45380 **Colonoscopy, flexible; with biopsy, single or multiple** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,054,879

2021 Work RVU: 3.56
2021 NF PE RVU: 9.25
2021 Fac PE RVU: 1.87

RUC Recommendation: 3.66 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45381 **Colonoscopy, flexible; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS Fastest Growing / MPC List / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** October 2008 **2019 est Medicare Utilization:** 82,892

2021 Work RVU: 3.56
2021 NF PE RVU: 9.36
2021 Fac PE RVU: 1.87

RUC Recommendation: 3.67 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2010

45382 **Colonoscopy, flexible; with control of bleeding, any method** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 24,121

2021 Work RVU: 4.66
2021 NF PE RVU: 16.07
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.76 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45383 **Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

45384 **Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 77,739

2021 Work RVU: 4.07
2021 NF PE RVU: 10.23
2021 Fac PE RVU: 2.01

RUC Recommendation: 4.17 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45385 **Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List / Codes Reported Together 75%or More-Part4 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 971,282

2021 Work RVU: 4.57
2021 NF PE RVU: 8.62
2021 Fac PE RVU: 2.31

RUC Recommendation: 4.57 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45386 **Colonoscopy, flexible; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,321

2021 Work RVU: 3.77
2021 NF PE RVU: 14.77
2021 Fac PE RVU: 1.94

RUC Recommendation: 3.87 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45387 **Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)** **Global:** **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45388 **Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 26,744

2021 Work RVU: 4.88
2021 NF PE RVU: 79.44
2021 Fac PE RVU: 2.41

RUC Recommendation: 4.98 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45389 **Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 420

2021 Work RVU: 5.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.60

RUC Recommendation: 5.50 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45390 **Colonoscopy, flexible; with endoscopic mucosal resection** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 23,129

2021 Work RVU: 6.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 6.35 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45391 **Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 932

2021 Work RVU: 4.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.95 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45392 **Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 86

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 5.60 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45393 **Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,112

2021 Work RVU: 4.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 4.78 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45398 **Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 3,509

2021 Work RVU: 4.20
2021 NF PE RVU: 20.44
2021 Fac PE RVU: 2.06

RUC Recommendation: 4.30 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

46020 **Placement of seton**

Global: 010 **Issue:** Placement/Removal of Seton **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 16 **Specialty Developing Recommendation:** ACS, ASCRS (col) **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,325

2021 Work RVU: 3.00
2021 NF PE RVU: 4.92
2021 Fac PE RVU: 3.50

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

46030 **Removal of anal seton, other marker**

Global: 010 **Issue:** Placement/ Removal of Seton **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 16 **Specialty Developing Recommendation:** ACS, ASCRS (col) **First Identified:** April 2020 **2019 est Medicare Utilization:** 339

2021 Work RVU: 1.26
2021 NF PE RVU: 3.09
2021 Fac PE RVU: 1.17

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

46200 **Fissurectomy, including sphincterotomy, when performed**

Global: 090 **Issue:** Fissurectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 992

2021 Work RVU: 3.59
2021 NF PE RVU: 10.05
2021 Fac PE RVU: 5.72

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

46500 **Injection of sclerosing solution, hemorrhoids**

Global: 010 **Issue:** Hemorrhoid Injection **Screen:** 010-Day Global Post-Operative Visits / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 24 **Specialty Developing Recommendation:** ACS, ASCRS (colon) **First Identified:** January 2014 **2019 est Medicare Utilization:** 12,575

2021 Work RVU: 1.74
2021 NF PE RVU: 7.52
2021 Fac PE RVU: 3.53

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47011 **Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47135 **Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age**

Global: 090 **Issue:** Liver Allotransplantation **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACS, ASTS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,590

2021 Work RVU: 90.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 46.85

RUC Recommendation: 91.78 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47136 **Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age**

Global: **Issue:** RAW **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** ACS, ASTS **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47382 **Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency**

Global: 010 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 3,121

2021 Work RVU: 14.97
2021 NF PE RVU: 108.30
2021 Fac PE RVU: 5.04

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47490 **Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation**

Global: 010 **Issue:** Cholecystostomy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACR

First Identified: October 2008 **2019 est Medicare Utilization:** 12,075

2021 Work RVU: 4.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.55

RUC Recommendation: 4.76 **Referred to CPT** June 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

47500 **Injection procedure for percutaneous transhepatic cholangiography**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47505 **Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47510 **Introduction of percutaneous transhepatic catheter for biliary drainage**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47511 **Introduction of percutaneous transhepatic stent for internal and external biliary drainage**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47525 **Change of percutaneous biliary drainage catheter**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47530 **Revision and/or reinsertion of transhepatic tube**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47531 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 8,621

2021 Work RVU: 1.30
2021 NF PE RVU: 11.26
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.30 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47532 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 549

2021 Work RVU: 4.25
2021 NF PE RVU: 21.37
2021 Fac PE RVU: 1.49

RUC Recommendation: 4.50 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47533 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,518

2021 Work RVU: 5.38
2021 NF PE RVU: 31.52
2021 Fac PE RVU: 1.79

RUC Recommendation: 5.63 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47534 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; internal-external**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 4,467

2021 Work RVU: 7.60
2021 NF PE RVU: 33.18
2021 Fac PE RVU: 2.42

RUC Recommendation: 7.85 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47535 **Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 438

2021 Work RVU: 3.95
2021 NF PE RVU: 24.60
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.20 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47536 **Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 14,577

2021 Work RVU: 2.61
2021 NF PE RVU: 17.79
2021 Fac PE RVU: 0.96

RUC Recommendation: 2.86 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47537 **Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,737

2021 Work RVU: 1.84
2021 NF PE RVU: 12.71
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.85 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47538 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,025

2021 Work RVU: 4.75
2021 NF PE RVU: 120.85
2021 Fac PE RVU: 1.62

RUC Recommendation: 5.00 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47539 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 135

2021 Work RVU: 8.75
2021 NF PE RVU: 128.69
2021 Fac PE RVU: 2.55

RUC Recommendation: 9.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47540 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 223

2021 Work RVU: 9.03
2021 NF PE RVU: 131.53
2021 Fac PE RVU: 2.84

RUC Recommendation: 9.28 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47541 **Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 170

2021 Work RVU: 6.75
2021 NF PE RVU: 29.20
2021 Fac PE RVU: 2.22

RUC Recommendation: 7.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47542 **Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,346

2021 Work RVU: 2.85
2021 NF PE RVU: 12.52
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.85 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47543 **Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 692

2021 Work RVU: 3.00
2021 NF PE RVU: 9.70
2021 Fac PE RVU: 0.89

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47544 **Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 322

2021 Work RVU: 3.28
2021 NF PE RVU: 24.66
2021 Fac PE RVU: 0.93

RUC Recommendation: 3.28 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47560 **Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy**

Global: **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:**

First Identified: July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

47562 **Laparoscopy, surgical; cholecystectomy**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ACS

First Identified: September 2011 **2019 est Medicare Utilization:** 100,881

2021 Work RVU: 10.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.54

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

47563 **Laparoscopy, surgical; cholecystectomy with cholangiography**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:** 38,983

2021 Work RVU: 11.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.04

RUC Recommendation: No further action. 12.11 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47600 **Cholecystectomy;**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 8,195

2021 Work RVU: 17.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.02

RUC Recommendation: 20.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47605 **Cholecystectomy; with cholangiography**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,408

2021 Work RVU: 18.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.45

RUC Recommendation: 21.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

48102 **Biopsy of pancreas, percutaneous needle**

Global: 010 **Issue:** Percutaneous Needle Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** SIR **First Identified:** September 2007 **2019 est Medicare Utilization:** 960

2021 Work RVU: 4.70
2021 NF PE RVU: 10.86
2021 Fac PE RVU: 1.75

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

48511 **External drainage, pseudocyst of pancreas; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49021 **Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49041 **Drainage of subdiaphragmatic or subphrenic abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49061 **Drainage of retroperitoneal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49080 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial**

Global: **Issue:** Peritoneocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49081 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent**

Global: **Issue:** Peritoneocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49082 **Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,210

2021 Work RVU: 1.24
2021 NF PE RVU: 5.06
2021 Fac PE RVU: 0.72

RUC Recommendation: 1.35 **Referred to CPT** June 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49083 **Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 265,269

2021 Work RVU: 2.00
2021 NF PE RVU: 6.90
2021 Fac PE RVU: 0.91

RUC Recommendation: 2.00 **Referred to CPT** June 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49084 **Peritoneal lavage, including imaging guidance, when performed** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,879

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.75

RUC Recommendation: 2.50 **Referred to CPT** June 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49405 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 5,880

2021 Work RVU: 4.00
2021 NF PE RVU: 22.98
2021 Fac PE RVU: 1.32

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49406 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 33,397

2021 Work RVU: 4.00
2021 NF PE RVU: 22.99
2021 Fac PE RVU: 1.32

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49407 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 243

2021 Work RVU: 4.25
2021 NF PE RVU: 18.03
2021 Fac PE RVU: 1.36

RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49418 **Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous**

Global: 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,497

2021 Work RVU: 3.96
2021 NF PE RVU: 29.31
2021 Fac PE RVU: 1.50

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49420 **Deleted from CPT**

Global: **Issue:** Insertion of Intraperitoneal Cannula or Catheter **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49421 **Insertion of tunneled intraperitoneal catheter for dialysis, open**

Global: 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,848

2021 Work RVU: 4.21
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.53

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49422 **Removal of tunneled intraperitoneal catheter**

Global: 000 **Issue:** Removal of Intraperitoneal Catheter **Screen:** Site of Service Anomaly - 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACS, SVS

First Identified: October 2016

2019 est Medicare Utilization: 12,368

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.62

RUC Recommendation: 4.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

49505 **Repair initial inguinal hernia, age 5 years or older; reducible**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** ACS

First Identified: September 2011

2019 est Medicare Utilization: 50,710

2021 Work RVU: 7.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.60

RUC Recommendation: Reaffirmed

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

49507 **Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated**

Global: 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 29 **Specialty Developing Recommendation:** ACS

First Identified: September 2007

2019 est Medicare Utilization: 10,329

2021 Work RVU: 9.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.12

RUC Recommendation: 10.05

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

49521 **Repair recurrent inguinal hernia, any age; incarcerated or strangulated**

Global: 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 29 **Specialty Developing Recommendation:** ACS

First Identified: September 2007

2019 est Medicare Utilization: 1,809

2021 Work RVU: 11.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.00

RUC Recommendation: 12.44

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

49565 **Repair recurrent incisional or ventral hernia; reducible**

Global: 090 **Issue:** Repair Recurrent Hernia **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 24 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,211

2021 Work RVU: 12.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.46

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

49587 **Repair umbilical hernia, age 5 years or older; incarcerated or strangulated**

Global: 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 29 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,947

2021 Work RVU: 7.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.37

RUC Recommendation: 8.04 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49652 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible**

Global: 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2019 est Medicare Utilization:** 9,327

2021 Work RVU: 11.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.26

RUC Recommendation: 12.88 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49653 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated**

Global: 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2019 est Medicare Utilization:** 5,848

2021 Work RVU: 14.94
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.02

RUC Recommendation: 16.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49654 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible**

Global: 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2019 est Medicare Utilization:** 7,253

2021 Work RVU: 13.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.95

RUC Recommendation: 15.03 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

49655 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated**

Global: 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 30 **Specialty Developing Recommendation:** ACS **First Identified:** June 2010 **2019 est Medicare Utilization:** 4,804

2021 Work RVU: 16.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.73

RUC Recommendation: 18.11 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50021 **Drainage of perirenal or renal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50080 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm**

Global: 090 **Issue:** Percutaneous Nephrostolithotomy **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 25 **Specialty Developing Recommendation:** AUA **First Identified:** October 2019 **2019 est Medicare Utilization:** 2,659

2021 Work RVU: 15.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.75

RUC Recommendation: Refer to CPT **Referred to CPT** May 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

50081 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm**

Global: 090 **Issue:** Percutaneous Nephrostolithotomy **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 25 **Specialty Developing Recommendation:** AUA **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,937

2021 Work RVU: 23.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.97

RUC Recommendation: Refer to CPT **Referred to CPT** May 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

50200 **Renal biopsy; percutaneous, by trocar or needle**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 38,395

2021 Work RVU: 2.38
2021 NF PE RVU: 13.71
2021 Fac PE RVU: 1.10

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50360 **Renal allotransplantation, implantation of graft; without recipient nephrectomy** **Global:** 090 **Issue:** Renal Allotransplantation **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** July 2012 **2019 est Medicare Utilization:** 12,479

2021 Work RVU: 39.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 22.26

RUC Recommendation: 40.90 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50387 **Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation** **Global:** 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 7,721

2021 Work RVU: 1.75
2021 NF PE RVU: 15.40
2021 Fac PE RVU: 0.51

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50392 **Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous** **Global:** **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50393 **Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50394 **Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50395 **Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous**

Global: **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50398 **Change of nephrostomy or pyelostomy tube**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50430 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,007

2021 Work RVU: 2.90
2021 NF PE RVU: 15.41
2021 Fac PE RVU: 1.28

RUC Recommendation: 3.15 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50431 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 8,818

2021 Work RVU: 1.10
2021 NF PE RVU: 7.92
2021 Fac PE RVU: 0.69

RUC Recommendation: 1.42 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50432 **Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 28,285

2021 Work RVU: 4.00
2021 NF PE RVU: 23.39
2021 Fac PE RVU: 1.57

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50433 **Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 5,572

2021 Work RVU: 5.05
2021 NF PE RVU: 29.70
2021 Fac PE RVU: 1.85

RUC Recommendation: 5.05 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50434 **Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 2,477

2021 Work RVU: 3.75
2021 NF PE RVU: 24.12
2021 Fac PE RVU: 1.45

RUC Recommendation: 4.20 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50435 **Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 46,684

2021 Work RVU: 1.82
2021 NF PE RVU: 16.19
2021 Fac PE RVU: 0.89

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50436 **Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed;**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 607

2021 Work RVU: 2.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.31

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

50437 **Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed; including new access into the renal collecting system**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,196

2021 Work RVU: 4.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.93

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50542 **Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** AUA

First Identified: October 2008 **2019 est Medicare Utilization:** 197

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.11

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

50548 **Laparoscopy, surgical; nephrectomy with total ureterectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** AUA

First Identified: October 2008 **2019 est Medicare Utilization:** 2,422

2021 Work RVU: 25.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.78

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

50590 **Lithotripsy, extracorporeal shock wave**

Global: 090 **Issue:** Lithotripsy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 42 **Specialty Developing Recommendation:** AUA

First Identified: September 2011 **2019 est Medicare Utilization:** 54,658

2021 Work RVU: 9.77
2021 NF PE RVU: 11.03
2021 Fac PE RVU: 5.72

RUC Recommendation: 9.77

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

50605 **Ureterotomy for insertion of indwelling stent, all types**

Global: 090 **Issue:** Ureterotomy **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AUA, SIR

First Identified: October 2008 **2019 est Medicare Utilization:** 3,602

2021 Work RVU: 16.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.05

RUC Recommendation: Review action plan at the RAW Oct 2015. CPT Assistant article published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

50606 **Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 104

2021 Work RVU: 3.16
2021 NF PE RVU: 13.99
2021 Fac PE RVU: 0.91

RUC Recommendation: 3.16 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50693 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,504

2021 Work RVU: 3.96
2021 NF PE RVU: 27.17
2021 Fac PE RVU: 1.58

RUC Recommendation: 4.60 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50694 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 981

2021 Work RVU: 5.25
2021 NF PE RVU: 29.30
2021 Fac PE RVU: 1.99

RUC Recommendation: 6.00 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50695 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,321

2021 Work RVU: 6.80
2021 NF PE RVU: 34.84
2021 Fac PE RVU: 2.52

RUC Recommendation: 7.55 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50705 **Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 65

2021 Work RVU: 4.03
2021 NF PE RVU: 53.59
2021 Fac PE RVU: 0.65

RUC Recommendation: 4.03 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50706 **Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,459

2021 Work RVU: 3.80
2021 NF PE RVU: 23.29
2021 Fac PE RVU: 1.11

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51040 **Cystostomy, cystotomy with drainage**

Global: 090 **Issue:** Cystostomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 5,029

2021 Work RVU: 4.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.48

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

51102 **Aspiration of bladder; with insertion of suprapubic catheter**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 14,265

2021 Work RVU: 2.70
2021 NF PE RVU: 4.21
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

51700 **Bladder irrigation, simple, lavage and/or instillation**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 194,801

2021 Work RVU: 0.60
2021 NF PE RVU: 1.63
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.60

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

51701 **Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 168,108

2021 Work RVU: 0.50
2021 NF PE RVU: 0.78
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

51702 **Insertion of temporary indwelling bladder catheter; simple (eg, Foley)** **Global:** 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 234,004

2021 Work RVU: 0.50
2021 NF PE RVU: 1.32
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

51703 **Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)** **Global:** 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 54,647

2021 Work RVU: 1.47
2021 NF PE RVU: 2.73
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.47 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

51720 **Bladder instillation of anticarcinogenic agent (including retention time)** **Global:** 000 **Issue:** Treatment of Bladder Lesion **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 33 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 160,447

2021 Work RVU: 0.87
2021 NF PE RVU: 1.64
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51726 **Complex cystometrogram (ie, calibrated electronic equipment);** **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,438

2021 Work RVU: 1.71
2021 NF PE RVU: 7.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.71 **Referred to CPT** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51727 **Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,982

2021 Work RVU: 2.11
2021 NF PE RVU: 8.52
2021 Fac PE RVU: NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51728 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 85,150

2021 Work RVU: 2.11
2021 NF PE RVU: 8.65
2021 Fac PE RVU: NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51729 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,880

2021 Work RVU: 2.51
2021 NF PE RVU: 8.84
2021 Fac PE RVU: NA

RUC Recommendation: 2.51 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51736 **Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 11 **Specialty Developing Recommendation:** AUA **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,797

2021 Work RVU: 0.17
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51741 **Complex uroflowmetry (eg, calibrated electronic equipment)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 11 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 423,494

2021 Work RVU: 0.17
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51772 **Deleted from CPT** **Global:** **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51784 **Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique**

Global: XXX **Issue:** Electromyography Studies (EMG) **Screen:** Codes Reported Together 75% or More-Part2 / CMS High Expenditure Procedural Codes2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 142,000

2021 Work RVU: 0.75
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.75. Maintain, CPT Assistant addressed issues identified.

Referred to CPT February 2014 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2014

51792 **Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)**

Global: 000 **Issue:** Urinary Reflex Studies with EMG **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 7,152

2021 Work RVU: 1.10
2021 NF PE RVU: 6.72
2021 Fac PE RVU: NA

RUC Recommendation: CPT edits and CPT Assistant article complete.

Referred to CPT February 2014 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2014

51795 **Deleted from CPT**

Global: **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51797 **Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:**

First Identified: February 2008

2019 est Medicare Utilization: 116,064

2021 Work RVU: 0.80
2021 NF PE RVU: 4.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

51798 **Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging**

Global: XXX **Issue:** Voiding Pressure Studies **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 25 **Specialty Developing Recommendation:** AUA

First Identified: July 2015

2019 est Medicare Utilization: 2,169,510

2021 Work RVU: 0.00
2021 NF PE RVU: 0.29
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

52000 **Cystourethroscopy (separate procedure)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 35 **Specialty Developing Recommendation:** AUA, ACOG

First Identified: October 2010

2019 est Medicare Utilization: 897,375

2021 Work RVU: 1.53
2021 NF PE RVU: 5.21
2021 Fac PE RVU: 0.63

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52214 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth1 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2019 est Medicare Utilization:** 16,853

2021 Work RVU: 3.50
2021 NF PE RVU: 19.06
2021 Fac PE RVU: 1.20

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

52224 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy**

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth1 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 36,291

2021 Work RVU: 4.05
2021 NF PE RVU: 19.41
2021 Fac PE RVU: 1.39

RUC Recommendation: 4.05 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

52234 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 28,317

2021 Work RVU: 4.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.96

RUC Recommendation: 4.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

Status Report: CMS Requests and Relativity Assessment Issues

52235 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2019 est Medicare Utilization:** 33,411

2021 Work RVU: 5.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.27

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

52240 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,956

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 8.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

52281 **Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 38 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 62,618

2021 Work RVU: 2.75
2021 NF PE RVU: 6.79
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52287 **Cystourethroscopy, with injection(s) for chemodenervation of the bladder** **Global:** 000 **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 51,037

2021 Work RVU: 3.20
2021 NF PE RVU: 7.82
2021 Fac PE RVU: 1.32

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

52332 **Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)** **Global:** 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 151,015

2021 Work RVU: 2.82
2021 NF PE RVU: 9.94
2021 Fac PE RVU: 1.35

RUC Recommendation: 2.82 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

52334 **Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde** **Global:** 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 289

2021 Work RVU: 3.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.54

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52341 **Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 2,487

2021 Work RVU: 5.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.24

RUC Recommendation: 5.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52342 **Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 191

2021 Work RVU: 5.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.85 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52343 **Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 21

2021 Work RVU: 6.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.65

RUC Recommendation: 6.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52344 **Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,393

2021 Work RVU: 7.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.82

RUC Recommendation: 7.05 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52345 **Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 480

2021 Work RVU: 7.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.00

RUC Recommendation: 7.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52346 **Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 212

2021 Work RVU: 8.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.35

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52351 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 22,929

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.34

RUC Recommendation: 5.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52352 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 24,811

2021 Work RVU: 6.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.72

RUC Recommendation: 6.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52353 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2019 est Medicare Utilization:** 11,180

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 7.50 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52354 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 9,144

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

52355 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,007

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.49

RUC Recommendation: 10.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52356 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** January 2013 **2019 est Medicare Utilization:** 78,507

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.11

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52400 **Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 115

2021 Work RVU: 8.69
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.19

RUC Recommendation: 8.69 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52442 **Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PE Subcommittee **Screen:** PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AUA, AACU **First Identified:** April 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 1.01
2021 NF PE RVU: 28.12
2021 Fac PE RVU: 0.35

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52500 **Transurethral resection of bladder neck (separate procedure)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,173

2021 Work RVU: 8.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.24

RUC Recommendation: 8.14 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52601 **Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)** **Global:** 090 **Issue:** Transurethral Electrosurgical Resection of Prostate (TURP) **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2015 **2019 est Medicare Utilization:** 44,942

2021 Work RVU: 13.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.56

RUC Recommendation: 13.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52640 **Transurethral resection; of postoperative bladder neck contracture** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,396

2021 Work RVU: 4.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.98

RUC Recommendation: 4.79 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52648 **Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)**

Global: 090 **Issue:** Laser Surgery of Prostate **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 18,059

2021 Work RVU: 12.15
2021 NF PE RVU: 36.73
2021 Fac PE RVU: 6.60

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

53445 **Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,071

2021 Work RVU: 13.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.55

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

53850 **Transurethral destruction of prostate tissue; by microwave thermotherapy**

Global: 090 **Issue:** Transurethral Destruction of Prostate Tissue **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 43 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,363

2021 Work RVU: 5.42
2021 NF PE RVU: 40.18
2021 Fac PE RVU: 4.25

RUC Recommendation: 10.08 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

54405 **Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 5,217

2021 Work RVU: 14.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.40

RUC Recommendation: 14.39

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

54410 **Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 31 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 1,286

2021 Work RVU: 15.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.22

RUC Recommendation: 15.18

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

54520 **Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach**

Global: 090 **Issue:** Removal of Testical **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 2,671

2021 Work RVU: 5.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.61

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

54530 **Orchiectomy, radical, for tumor; inguinal approach**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 1,190

2021 Work RVU: 8.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.37

RUC Recommendation: 8.46

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

55700 **Biopsy, prostate; needle or punch, single or multiple, any approach**

Global: 000 **Issue:** Biopsy of Prostate **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 36 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 156,362

2021 Work RVU: 2.50
2021 NF PE RVU: 4.57
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

55706 **Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,297

2021 Work RVU: 6.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.95

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

55840 **Prostatectomy, retropubic radical, with or without nerve sparing;**

Global: 090 **Issue:** **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** October 2013 **2019 est Medicare Utilization:** 1,610

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.22

RUC Recommendation: 21.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

55842 **Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)**

Global: 090 **Issue:** **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** October 2013 **2019 est Medicare Utilization:** 150

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.24

RUC Recommendation: 24.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55845 **Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes**

Global: 090 **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,030

2021 Work RVU: 25.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.53

RUC Recommendation: 29.07 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55866 **Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed**

Global: 090 **Issue:** Laparoscopic Radical Prostatectomy **Screen:** New Technology / CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 27 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 20,334

2021 Work RVU: 26.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.05

RUC Recommendation: 26.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55873 **Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)**

Global: 090 **Issue:** Cryoablation of Prostate **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 25 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,648

2021 Work RVU: 13.60
2021 NF PE RVU: 171.52
2021 Fac PE RVU: 7.11

RUC Recommendation: 13.45 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55875 **Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy**

Global: 090 **Issue:** RAW **Screen:** RUC request **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 6,399

2021 Work RVU: 13.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.66

RUC Recommendation: Review data at RAW

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Not Part of RAW

56515 **Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)**

Global: 010 **Issue:** Destruction of Lesions **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACOG

First Identified: September 2007

2019 est Medicare Utilization: 3,187

2021 Work RVU: 3.08
2021 NF PE RVU: 4.41
2021 Fac PE RVU: 2.65

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

56620 **Vulvectomy simple; partial**

Global: 090 **Issue:** Partial Removal of Vulva **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** D **Specialty Developing Recommendation:** ACOG

First Identified: September 2007

2019 est Medicare Utilization: 3,143

2021 Work RVU: 7.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.20

RUC Recommendation: 7.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

57150 **Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease**

Global: 000 **Issue:** Vaginal Treatments **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 15 **Specialty Developing Recommendation:** ACOG

First Identified: July 2016

2019 est Medicare Utilization: 24,482

2021 Work RVU: 0.50
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

57155 **Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy** **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,111

2021 Work RVU: 5.15
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 2.64

RUC Recommendation: 5.40 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57156 **Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy** **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 15,369

2021 Work RVU: 2.69
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 1.47

RUC Recommendation: 2.69 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57160 **Fitting and insertion of pessary or other intravaginal support device** **Global:** 000 **Issue:** Vaginal Treatments **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 15 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 85,733

2021 Work RVU: 0.89
2021 NF PE RVU: 1.11
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.89 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57240 **Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2015 **2019 est Medicare Utilization:** 9,026

2021 Work RVU: 10.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.44

RUC Recommendation: 10.08 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57250 **Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 8,757

2021 Work RVU: 10.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.48

RUC Recommendation: 10.08 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57260 **Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 9,740

2021 Work RVU: 13.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.67

RUC Recommendation: 13.25 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57265 **Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 4,370

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.38

RUC Recommendation: 15.00 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57282 **Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)** **Global:** 090 **Issue:** Colpopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 7,042

2021 Work RVU: 11.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.05

RUC Recommendation: 13.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

57283 **Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)** **Global:** 090 **Issue:** Colpopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,777

2021 Work RVU: 11.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.11

RUC Recommendation: 13.51 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

57287 **Removal or revision of sling for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,737

2021 Work RVU: 11.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.93

RUC Recommendation: 10.97 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57288 **Sling operation for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Sling Operation for Stress Incontinence **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** O **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 25,452

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.93

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57425 **Laparoscopy, surgical, colpopexy (suspension of vaginal apex)** **Global:** 090 **Issue:** Laparoscopic Colopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 27 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 9,468

2021 Work RVU: 17.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.10

RUC Recommendation: 18.02 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

58100 **Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)** **Global:** 000 **Issue:** Biopsy of Uterus Lining **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 68,910

2021 Work RVU: 1.21
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.21 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58110 **Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Biopsy of Uterus Lining **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2017 **2019 est Medicare Utilization:** 672

2021 Work RVU: 0.77
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58555 **Hysteroscopy, diagnostic (separate procedure)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 1,494

2021 Work RVU: 2.65
2021 NF PE RVU: 7.57
2021 Fac PE RVU: 1.38

RUC Recommendation: 3.07 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58558 **Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 47,694

2021 Work RVU: 4.17
2021 NF PE RVU: 38.05
2021 Fac PE RVU: 1.96

RUC Recommendation: 4.37 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58559 **Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 121

2021 Work RVU: 5.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.35

RUC Recommendation: 5.54 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58560 **Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 44

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.55

RUC Recommendation: 6.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58561 **Hysteroscopy, surgical; with removal of leiomyomata**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 2,396

2021 Work RVU: 6.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.89

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58562 **Hysteroscopy, surgical; with removal of impacted foreign body**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 206

2021 Work RVU: 4.00
2021 NF PE RVU: 8.07
2021 Fac PE RVU: 1.88

RUC Recommendation: 4.17 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58563 **Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 2,831

2021 Work RVU: 4.47
2021 NF PE RVU: 59.54
2021 Fac PE RVU: 2.06

RUC Recommendation: 4.62 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58660 **Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 761

2021 Work RVU: 11.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.43

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

58661 **Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)**

Global: 010 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 13,081

2021 Work RVU: 11.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.04

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58823 **Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

59400 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,825

2021 Work RVU: 36.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.40

RUC Recommendation: 32.69 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59409 **Vaginal delivery only (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,615

2021 Work RVU: 14.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.67

RUC Recommendation: 14.37 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59410 **Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 823

2021 Work RVU: 18.34
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.24

RUC Recommendation: 18.54 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59412 **External cephalic version, with or without tocolysis**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 29

2021 Work RVU: 1.71
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.71 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

59414 **Delivery of placenta (separate procedure)**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 56

2021 Work RVU: 1.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

59425 **Antepartum care only; 4-6 visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 666

2021 Work RVU: 7.80
2021 NF PE RVU: 6.63
2021 Fac PE RVU: 3.05

RUC Recommendation: 6.31 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

59426 **Antepartum care only; 7 or more visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 710

2021 Work RVU: 14.30
2021 NF PE RVU: 12.14
2021 Fac PE RVU: 5.62

RUC Recommendation: 11.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59430 **Postpartum care only (separate procedure)** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 1,138

2021 Work RVU: 3.22
2021 NF PE RVU: 3.59
2021 Fac PE RVU: 1.26

RUC Recommendation: 2.47 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59510 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,365

2021 Work RVU: 40.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 26.09

RUC Recommendation: 36.17 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59514 **Cesarean delivery only;** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,266

2021 Work RVU: 16.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.25

RUC Recommendation: 16.13 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59515 **Cesarean delivery only; including postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 760

2021 Work RVU: 22.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.19

RUC Recommendation: 22.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59610 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 89

2021 Work RVU: 38.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.53

RUC Recommendation: 34.40 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59612 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 65

2021 Work RVU: 16.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.14

RUC Recommendation: 16.09 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59614 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 36

2021 Work RVU: 20.06
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.11

RUC Recommendation: 20.26 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59618 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 22

2021 Work RVU: 40.91
2021 NF PE RVU: NA
2021 Fac PE RVU: 26.17

RUC Recommendation: 36.69 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59620 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 13

2021 Work RVU: 16.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.36

RUC Recommendation: 16.66 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

59622 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 6

2021 Work RVU: 22.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.81

RUC Recommendation: 22.53 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

60220 **Total thyroid lobectomy, unilateral; with or without isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,841

2021 Work RVU: 11.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.47

RUC Recommendation: 12.29 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60225 **Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 308

2021 Work RVU: 14.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.89

RUC Recommendation: 14.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

60520 **Thymectomy, partial or total; transcervical approach (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2019 est Medicare Utilization:** 437

2021 Work RVU: 17.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.81

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

60521 **Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2019 est Medicare Utilization:** 254

2021 Work RVU: 19.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.29

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60522 **Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:**

First Identified: November 2011 **2019 est Medicare Utilization:** 120

2021 Work RVU: 23.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.24

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.

Referred to CPT **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

61055 **Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2014 **2019 est Medicare Utilization:** 293

2021 Work RVU: 2.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.06

RUC Recommendation: Editorial change

Referred to CPT October 2013 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

61781 **Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS

First Identified: October 2009 **2019 est Medicare Utilization:** 15,851

2021 Work RVU: 3.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.79

RUC Recommendation: 3.75

Referred to CPT October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61782 **Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAO-HNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 18,750

2021 Work RVU: 3.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 3.18 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61783 **Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 18,207

2021 Work RVU: 3.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.82

RUC Recommendation: 3.75 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61793 **Deleted from CPT**

Global: **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** AANS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61795 **Deleted from CPT** **Global:** **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** NASS, AAO-HNS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

61796 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 6,704

2021 Work RVU: 13.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.94

RUC Recommendation: 15.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61797 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 8,122

2021 Work RVU: 3.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.68

RUC Recommendation: 3.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61798 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 3,528

2021 Work RVU: 19.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.63

RUC Recommendation: 19.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61799 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:**

First Identified: NA

2019 est Medicare Utilization: 570

2021 Work RVU: 4.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.30

RUC Recommendation: 4.81

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61800 **Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 16 **Specialty Developing Recommendation:**

First Identified: February 2008

2019 est Medicare Utilization: 5,499

2021 Work RVU: 2.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 2.25

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61885 **Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array**

Global: 090 **Issue:** Vagal Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 14 **Specialty Developing Recommendation:** AANS/CNS

First Identified: September 2007

2019 est Medicare Utilization: 5,787

2021 Work RVU: 6.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.30

RUC Recommendation: 6.44

Referred to CPT October 2009

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62263 **Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days**

Global: 010 **Issue:** Epidual Lysis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 66 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 302

2021 Work RVU: 5.00
2021 NF PE RVU: 13.40
2021 Fac PE RVU: 3.59

RUC Recommendation: 6.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

62270 **Spinal puncture, lumbar, diagnostic;**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** ACR, ASNR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 79,126

2021 Work RVU: 1.22
2021 NF PE RVU: 2.50
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.44 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

62272 **Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 6,301

2021 Work RVU: 1.58
2021 NF PE RVU: 3.31
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.80 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62281 **Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic**

Global: 010 **Issue:** Injection of Neurolytic Agent **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 390

2021 Work RVU: 2.66
2021 NF PE RVU: 4.32
2021 Fac PE RVU: 1.76

RUC Recommendation: Remove 99238 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Q&A May 2010

62284 **Injection procedure for myelography and/or computed tomography, lumbar**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 16,213

2021 Work RVU: 1.54
2021 NF PE RVU: 4.18
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.54 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

62287 **Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar**

Global: 090 **Issue:** Percutaneous Diskectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 166

2021 Work RVU: 9.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.85

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62290 **Injection procedure for discography, each level; lumbar**

Global: 000 **Issue:** Injection for discography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, AUR, NASS, ACR, ASNR, ISIS, AANS **First Identified:** October 2009 **2019 est Medicare Utilization:** 7,115

2021 Work RVU: 3.00
2021 NF PE RVU: 7.65
2021 Fac PE RVU: 1.51

RUC Recommendation: 3.00, CPT Assistant article published.

Referred to CPT **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2011

62302 **Myelography via lumbar injection, including radiological supervision and interpretation; cervical**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 4,191

2021 Work RVU: 2.29
2021 NF PE RVU: 5.30
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.29

Referred to CPT October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62303 **Myelography via lumbar injection, including radiological supervision and interpretation; thoracic**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 411

2021 Work RVU: 2.29
2021 NF PE RVU: 5.43
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.29

Referred to CPT October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62304 **Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 18,417

2021 Work RVU: 2.25
2021 NF PE RVU: 5.25
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.25 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62305 **Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 6,616

2021 Work RVU: 2.35
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 1.03

RUC Recommendation: 2.35 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62310 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62311 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

62318 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

62319 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62320 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 5,631

2021 Work RVU: 1.80
2021 NF PE RVU: 2.89
2021 Fac PE RVU: 0.87

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62321 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 217,240

2021 Work RVU: 1.95
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 1.00

RUC Recommendation: 1.95 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62322 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 42,693

2021 Work RVU: 1.55
2021 NF PE RVU: 2.55
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.55 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62323 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 699,990

2021 Work RVU: 1.80
2021 NF PE RVU: 5.88
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62324 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 19,559

2021 Work RVU: 1.89
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.89 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62325 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 1,225

2021 Work RVU: 2.20
2021 NF PE RVU: 5.21
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.20 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62326 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 4,644

2021 Work RVU: 1.78
2021 NF PE RVU: 2.31
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.78 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62327 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 1,995

2021 Work RVU: 1.90
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.90 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62328 **Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 5.71
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.95 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

62329 **Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.03
2021 NF PE RVU: 7.22
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.25 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62350 **Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,884

2021 Work RVU: 6.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.53

RUC Recommendation: 6.05 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62355 **Removal of previously implanted intrathecal or epidural catheter**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,056

2021 Work RVU: 3.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.71

RUC Recommendation: 4.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62360 **Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 242

2021 Work RVU: 4.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.12

RUC Recommendation: 4.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62361 **Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** April 2008 **2019 est Medicare Utilization:** 36

2021 Work RVU: 5.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.90

RUC Recommendation: 5.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62362 **Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 8,146

2021 Work RVU: 5.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.53

RUC Recommendation: 6.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62365 **Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,266

2021 Work RVU: 3.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.88

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62367 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 10,982

2021 Work RVU: 0.48
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.19

RUC Recommendation: New PE inputs. 0.48 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62368 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 43,410

2021 Work RVU: 0.67
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.27

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62369 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 31,581

2021 Work RVU: 0.67
2021 NF PE RVU: 2.09
2021 Fac PE RVU: 0.28

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62370 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 101,707

2021 Work RVU: 0.90
2021 NF PE RVU: 1.90
2021 Fac PE RVU: 0.36

RUC Recommendation: New PE inputs. 1.10 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63030 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis / Site of Service Anomaly - 2018 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AANS, AAOS, NASS **First Identified:** January 2014 **2019 est Medicare Utilization:** 27,404

2021 Work RVU: 13.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.67

RUC Recommendation: Refer to CPT **Referred to CPT** May 2021 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63042 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AANS, AAOS, NASS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,851

2021 Work RVU: 18.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.29

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63045 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical**

Global: 090 **Issue:** Laminectomy **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 16 **Specialty Developing Recommendation:** **First Identified:** November 2013 **2019 est Medicare Utilization:** 10,977

2021 Work RVU: 17.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.22

RUC Recommendation: 17.95 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63046 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic**

Global: 090 **Issue:** Laminectomy **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 16 **Specialty Developing Recommendation:**

First Identified: November 2013 **2019 est Medicare Utilization:** 4,057

2021 Work RVU: 17.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.73

RUC Recommendation: 17.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63047 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar**

Global: 090 **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 24 **Specialty Developing Recommendation:** NASS, AANS

First Identified: September 2011 **2019 est Medicare Utilization:** 101,838

2021 Work RVU: 15.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.73

RUC Recommendation: 15.37 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63048 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 24 **Specialty Developing Recommendation:** NASS, AANS

First Identified: January 2012 **2019 est Medicare Utilization:** 128,927

2021 Work RVU: 3.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 3.47 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63056 **Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 6,048

2021 Work RVU: 21.86
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.52

RUC Recommendation: Review action plan at RAW Oct 2015. Maintain **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

63075 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

Global: 090 **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 428

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.62

RUC Recommendation: 19.60 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63076 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2019 est Medicare Utilization:** 313

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.99

RUC Recommendation: 4.04 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63090 **Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment**

Global: 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, AANS **First Identified:** January 2015 **2019 est Medicare Utilization:** 719

2021 Work RVU: 30.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.02

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

63620 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion**

Global: 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 492

2021 Work RVU: 15.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.77

RUC Recommendation: 15.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63621 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 160

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.92

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63650 **Percutaneous implantation of neurostimulator electrode array, epidural** **Global:** 010 **Issue:** Percutaneous implantation of neurostimulator **Screen:** Site of Service Anomaly / CMS Fastest Growing / CMS Request - Final Rule for 2013 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 92,083

2021 Work RVU: 7.15
2021 NF PE RVU: 58.56
2021 Fac PE RVU: 4.24

RUC Recommendation: 7.20. New PE Inputs **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

63655 **Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural** **Global:** 090 **Issue:** Neurostimulator (Spinal) **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 8,801

2021 Work RVU: 10.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.29

RUC Recommendation: 11.43 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63660 **Deleted from CPT** **Global:** **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63661 **Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 3,832

2021 Work RVU: 5.08
2021 NF PE RVU: 14.23
2021 Fac PE RVU: 3.61

RUC Recommendation: 5.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63662 **Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 2,414

2021 Work RVU: 11.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.47

RUC Recommendation: 10.87 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63663 **Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 1,584

2021 Work RVU: 7.75
2021 NF PE RVU: 17.85
2021 Fac PE RVU: 4.47

RUC Recommendation: 70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63664 **Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** **2019 est Medicare Utilization:** 692

2021 Work RVU: 11.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.73

RUC Recommendation: 11.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63685 **Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 29,921

2021 Work RVU: 5.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.42

RUC Recommendation: Refer to CPT Assistant. Review action plan in 2 years after CPT article published. 6.05 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:**

63688 **Revision or removal of implanted spinal neurostimulator pulse generator or receiver**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 8,593

2021 Work RVU: 5.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.54

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64405 **Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve** **Global:** 000 **Issue:** Injection - Greater Occipital Nerve **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 17 **Specialty Developing Recommendation:** AAN, AAPM, AAPMR, ASA **First Identified:** July 2016 **2019 est Medicare Utilization:** 134,871

2021 Work RVU: 0.94
2021 NF PE RVU: 1.04
2021 Fac PE RVU: 0.42

RUC Recommendation: 0.94 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

64412 **Injection, anesthetic agent; spinal accessory nerve** **Global:** **Issue:** Anesthetic Injection – Spinal Nerve **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 36 **Specialty Developing Recommendation:** AAN, ASA, AAPMR, ISIS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** FAQ Sept 2015

64415 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus** **Global:** 000 **Issue:** **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 199,150

2021 Work RVU: 1.35
2021 NF PE RVU: 1.89
2021 Fac PE RVU: 0.38

RUC Recommendation: Refer to CPT for bundling. 1.48 **Referred to CPT** May 2021 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

Status Report: CMS Requests and Relativity Assessment Issues

64416 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth2 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA

First Identified: September 2007 **2019 est Medicare Utilization:** 17,912

2021 Work RVU: 1.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.27

RUC Recommendation: Refer to CPT for bundling. Remove from screen. 1.81

Referred to CPT May 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64417 **Injection(s), anesthetic agent(s) and/or steroid; axillary nerve**

Global: 000 **Issue:** Somatic Nerve Injection **Screen:** part of New/Revised Review **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA

First Identified: October 2018 **2019 est Medicare Utilization:** 15,765

2021 Work RVU: 1.27
2021 NF PE RVU: 2.76
2021 Fac PE RVU: 0.39

RUC Recommendation: Refer to CPT

Referred to CPT May 2021 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

64418 **Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve**

Global: 000 **Issue:** Injection, Anesthetic Agent **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 28 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA

First Identified: October 2015 **2019 est Medicare Utilization:** 31,818

2021 Work RVU: 1.10
2021 NF PE RVU: 1.38
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.10

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64445 **Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve** **Global:** 000 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 130,719

2021 Work RVU: 1.00
2021 NF PE RVU: 2.68
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

64446 **Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,880

2021 Work RVU: 1.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.25

RUC Recommendation: Refer to CPT for bundling. 1.81 **Referred to CPT** May 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64447 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve** **Global:** 000 **Issue:** **Screen:** CMS Fastest Growing **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 282,703

2021 Work RVU: 1.10
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.35

RUC Recommendation: Refer to CPT for bundling. 1.50 **Referred to CPT** May 2021 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

Status Report: CMS Requests and Relativity Assessment Issues

64448 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 40,188

2021 Work RVU: 1.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.25

RUC Recommendation: Refer to CPT for Bundling. Remove from screen. 1.63 **Referred to CPT** May 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64449 **Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)**

Global: 000 **Issue:** Anesthetic Agent Nerve Injection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 19 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,957

2021 Work RVU: 1.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.81 **Referred to CPT** February 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64450 **Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch**

Global: 000 **Issue:** Somatic Nerve Injection **Screen:** Harvard Valued - Utilization over 100,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 09 **Specialty Developing Recommendation:** ASA, AAPM, APMA, ASIPP **First Identified:** October 2009 **2019 est Medicare Utilization:** 467,316

2021 Work RVU: 0.75
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.40

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2013

Status Report: CMS Requests and Relativity Assessment Issues

64455 **Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)**

Global: 000 **Issue:** Injection – Digital Nerves **Screen:** High Volume Growth4 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2016 **2019 est Medicare Utilization:** 74,450

2021 Work RVU: 0.75
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

64461 **Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)**

Global: 000 **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,096

2021 Work RVU: 1.75
2021 NF PE RVU: 2.05
2021 Fac PE RVU: 0.35

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

64462 **Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,483

2021 Work RVU: 1.10
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.24

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64463 **Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)**

Global: 000 **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,514

2021 Work RVU: 1.90
2021 NF PE RVU: 4.59
2021 Fac PE RVU: 0.35

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

64470 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64472 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64475 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64476 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64479 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 44,367

2021 Work RVU: 2.29
2021 NF PE RVU: 5.38
2021 Fac PE RVU: 1.32

RUC Recommendation: 2.29 **Referred to CPT** June 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

64480 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 19,219

2021 Work RVU: 1.20
2021 NF PE RVU: 2.66
2021 Fac PE RVU: 0.49

RUC Recommendation: 1.20 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64483 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level** **Global:** 000 **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,044,547

2021 Work RVU: 1.90
2021 NF PE RVU: 5.26
2021 Fac PE RVU: 1.18

RUC Recommendation: 1.90 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64484 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 431,178

2021 Work RVU: 1.00
2021 NF PE RVU: 2.19
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64490 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 265,103

2021 Work RVU: 1.82
2021 NF PE RVU: 3.71
2021 Fac PE RVU: 1.08

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64491 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 239,462

2021 Work RVU: 1.16
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64492 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 156,746

2021 Work RVU: 1.16
2021 NF PE RVU: 1.61
2021 Fac PE RVU: 0.50

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64493 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 901,171

2021 Work RVU: 1.52
2021 NF PE RVU: 3.58
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.52 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64494 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 809,666

2021 Work RVU: 1.00
2021 NF PE RVU: 1.59
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64495 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 456,363

2021 Work RVU: 1.00
2021 NF PE RVU: 1.59
2021 Fac PE RVU: 0.43

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64510 **Injection, anesthetic agent; stellate ganglion (cervical sympathetic)**

Global: 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2019 est Medicare Utilization:** 6,436

2021 Work RVU: 1.22
2021 NF PE RVU: 3.00
2021 Fac PE RVU: 0.90

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

64520 **Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)**

Global: 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2019 est Medicare Utilization:** 18,919

2021 Work RVU: 1.35
2021 NF PE RVU: 5.34
2021 Fac PE RVU: 0.97

RUC Recommendation: PE Review - no change **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64550 **Application of surface (transcutaneous) neurostimulator (eg, TENS unit)** **Global:** **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AANS, CNS, AOTA **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64553 **Percutaneous implantation of neurostimulator electrode array; cranial nerve** **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 15 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** July 2014 **2019 est Medicare Utilization:** 484

2021 Work RVU: 6.13
2021 NF PE RVU: 64.69
2021 Fac PE RVU: 3.71

RUC Recommendation: 6.13 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

64555 **Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)** **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** High Volume Growth1 / CMS Fastest Growing / Final Rule for 2015 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,342

2021 Work RVU: 5.76
2021 NF PE RVU: 58.65
2021 Fac PE RVU: 3.42

RUC Recommendation: 5.76. Article published Jan2016 and addressed issues. **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64561 **Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed**

Global: 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** CMS Fastest Growing / High Volume Growth2 / High Level E/M in Global Period / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AANS, CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 14,987

2021 Work RVU: 5.44
2021 NF PE RVU: 16.70
2021 Fac PE RVU: 2.74

RUC Recommendation: 5.44. 99214 visit appropriate. Remove from screen. **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64565 **Percutaneous implantation of neurostimulator electrode array; neuromuscular**

Global: **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 15 **Specialty Developing Recommendation:** AANS, CNS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64566 **Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming**

Global: 000 **Issue:** Posterior Tibial Neurostimulation **Screen:** CMS Request - Final Rule for 2014 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** July 2013 **2019 est Medicare Utilization:** 201,680

2021 Work RVU: 0.60
2021 NF PE RVU: 3.05
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64568 **Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator**

Global: 090 **Issue:** Vagus Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 14 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** **2019 est Medicare Utilization:** 1,002

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.98

RUC Recommendation: 11.19 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64573 **Deleted from CPT**

Global: **Issue:** Neurosurgical Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 28 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64581 **Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 10,284

2021 Work RVU: 12.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.51

RUC Recommendation: 12.20. 99214 visit appropriate. Remove from screen. **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64590 **Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** RAW **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 12,197

2021 Work RVU: 2.45
2021 NF PE RVU: 5.24
2021 Fac PE RVU: 1.92

RUC Recommendation: **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

64615 **Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)**

Global: 010 **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, NANS **First Identified:** October 2019 **2019 est Medicare Utilization:** 143,888

2021 Work RVU: 1.85
2021 NF PE RVU: 2.08
2021 Fac PE RVU: 1.18

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

64622 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level**

Global: **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: PE Review - no change **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64623 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)**

Global: **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64626 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level**

Global: **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: PE Review - no change **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64627 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)**

Global: **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1/ CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64633 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint**

Global: 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 86,013

2021 Work RVU: 3.84
2021 NF PE RVU: 8.33
2021 Fac PE RVU: 2.35

RUC Recommendation: 3.42 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

64634 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 135,589

2021 Work RVU: 1.32
2021 NF PE RVU: 4.21
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.32 **Referred to CPT** May 2015 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

64635 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint**

Global: 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 358,450

2021 Work RVU: 3.78
2021 NF PE RVU: 8.28
2021 Fac PE RVU: 2.33

RUC Recommendation: 3.42 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

Status Report: CMS Requests and Relativity Assessment Issues

64636 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 539,040

2021 Work RVU: 1.16
2021 NF PE RVU: 3.89
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.16 **Referred to CPT** May 2015 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2015

64640 **Destruction by neurolytic agent; other peripheral nerve or branch**

Global: 010 **Issue:** Injection Treatment of Nerve **Screen:** Site of Service Anomaly (99238-Only) / Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 25 **Specialty Developing Recommendation:** ASAM AAPM, APMA, ASIPP **First Identified:** September 2007 **2019 est Medicare Utilization:** 184,562

2021 Work RVU: 1.98
2021 NF PE RVU: 5.34
2021 Fac PE RVU: 1.29

RUC Recommendation: 1.23. Remove 99238. **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64708 **Neuroplasty, major peripheral nerve, arm or leg, open; other than specified**

Global: 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 69 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,356

2021 Work RVU: 6.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.44

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64712 **Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve** **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 705

2021 Work RVU: 8.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.85

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

64831 **Suture of digital nerve, hand or foot; 1 nerve** **Global:** 090 **Issue:** Neurorrhaphy – Finger **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 70 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2019 est Medicare Utilization:** 878

2021 Work RVU: 9.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.58

RUC Recommendation: 9.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

65105 **Enucleation of eye; with implant, muscles attached to implant** **Global:** 090 **Issue:** Ophthalmologic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 835

2021 Work RVU: 9.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.80

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

65205 **Removal of foreign body, external eye; conjunctival superficial** **Global:** 000 **Issue:** Removal of Foreign Body - Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** July 2016 **2019 est Medicare Utilization:** 26,275

2021 Work RVU: 0.49
2021 NF PE RVU: 0.33
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65210 **Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating**

Global: 000 **Issue:** Removal of Foreign Body - Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** July 2016 **2019 est Medicare Utilization:** 25,202

2021 Work RVU: 0.61
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.41

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

65222 **Removal of foreign body, external eye; corneal, with slit lamp**

Global: 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 26 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 24,544

2021 Work RVU: 0.84
2021 NF PE RVU: 1.09
2021 Fac PE RVU: 0.58

RUC Recommendation: 0.93 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

65285 **Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue**

Global: 090 **Issue:** Repair of Eye Wound **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 8 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 704

2021 Work RVU: 15.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.46

RUC Recommendation: 16.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65780 **Ocular surface reconstruction; amniotic membrane transplantation, multiple layers**

Global: 090 **Issue:** Ocular Reconstruction Transplant **Screen:** CMS Fastest Growing / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 31 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,974

2021 Work RVU: 7.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.94

RUC Recommendation: 8.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

65800 **Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous**

Global: 000 **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 21 **Specialty Developing Recommendation:** AAO **First Identified:** September 2011 **2019 est Medicare Utilization:** 20,137

2021 Work RVU: 1.53
2021 NF PE RVU: 1.82
2021 Fac PE RVU: 0.95

RUC Recommendation: 1.53 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

65805 **Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous**

Global: **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 21 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65855 **Trabeculoplasty by laser surgery**

Global: 010 **Issue:** Trabeculoplasty by Laser Surgery **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 143,167

2021 Work RVU: 3.00
2021 NF PE RVU: 3.96
2021 Fac PE RVU: 2.71

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66170 **Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery**

Global: 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 32 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 6,957

2021 Work RVU: 13.94
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.61

RUC Recommendation: 13.94 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66172 **Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic**

Global: 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 32 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 3,104

2021 Work RVU: 14.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.54

RUC Recommendation: 14.81 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66174 **Transluminal dilation of aqueous outflow canal; without retention of device or stent**

Global: 090 **Issue:** Dilation of Aqueous Outflow Canal **Screen:** New Technology/ New Service **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAO **First Identified:** April 2010 **2019 est Medicare Utilization:** 10,214

2021 Work RVU: 12.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.35

RUC Recommendation: 8.53 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66175 **Transluminal dilation of aqueous outflow canal; with retention of device or stent** **Global:** 090 **Issue:** Dilation of Aqueous Outflow Cana **Screen:** New Technology/ New Service **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAO **First Identified:** October 2020 **2019 est Medicare Utilization:** 223

2021 Work RVU: 13.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.88

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66179 **Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 802

2021 Work RVU: 14.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.15

RUC Recommendation: 14.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66180 **Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 10,715

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.76

RUC Recommendation: Maintain. 15.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66183 **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 4,674

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.57

RUC Recommendation: Maintain. 13.20 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

66184 **Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 594

2021 Work RVU: 9.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.53

RUC Recommendation: 9.58 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

66185 **Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,600

2021 Work RVU: 10.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.16

RUC Recommendation: Maintain. 10.58 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66711 **Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: October 2017

2019 est Medicare Utilization: 7,616

2021 Work RVU: 5.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.58

RUC Recommendation: 6.36

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

66761 **Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)**

Global: 010 **Issue:** Iridotomy **Screen:** High IWPUT / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO

First Identified: February 2008

2019 est Medicare Utilization: 67,836

2021 Work RVU: 3.00
2021 NF PE RVU: 5.56
2021 Fac PE RVU: 3.60

RUC Recommendation: Maintain. 3.00

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

66821 **Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more**

Global: 090 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** AAO

First Identified: October 2010

2019 est Medicare Utilization: 685,933

2021 Work RVU: 3.42
2021 NF PE RVU: 6.06
2021 Fac PE RVU: 5.36

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

66982 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 159,924

2021 Work RVU: 10.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.53

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

66983 **Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 93

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Contractor Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

66984 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High IWPUT / MPC List / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,694,951

2021 Work RVU: 7.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.83

RUC Recommendation: 7.35 **Referred to CPT** May 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66987 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 13.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66988 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

669X1

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 12.13 **Referred to CPT** October 2020 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

669X2

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 9.23 **Referred to CPT** October 2020 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67028 **Intravitreal injection of a pharmacologic agent (separate procedure)**

Global: 000 **Issue:** Treatment of Retinal Lesion **Screen:** High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 14 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,868,836

2021 Work RVU: 1.44
2021 NF PE RVU: 1.75
2021 Fac PE RVU: 1.11

RUC Recommendation: 1.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67036 **Vitrectomy, mechanical, pars plana approach;**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 18,016

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.84

RUC Recommendation: 12.13 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67038 **Deleted from CPT**

Global: **Issue:** Ophthalmological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2007 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

67039 **Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 3,357

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.50

RUC Recommendation: 13.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67040 **Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 8,666

2021 Work RVU: 14.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.31

RUC Recommendation: 14.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67041 **Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)**

Global: 090 **Issue:** Vitrectomy

Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab: 11

Specialty Developing Recommendation: AAO

First Identified: October 2012

2019 est Medicare Utilization: 13,146

2021 Work RVU: 16.33

2021 NF PE RVU: NA

2021 Fac PE RVU: 15.44

RUC Recommendation: 16.33

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67042 **Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)**

Global: 090 **Issue:** Vitrectomy

Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab: 11

Specialty Developing Recommendation: AAO

First Identified: October 2012

2019 est Medicare Utilization: 26,972

2021 Work RVU: 16.33

2021 NF PE RVU: NA

2021 Fac PE RVU: 15.44

RUC Recommendation: 16.33

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67043 **Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation**

Global: 090 **Issue:** Vitrectomy

Screen: Harvard-Valued Annual Allowed Charges Greater than $10 million

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab: 11

Specialty Developing Recommendation: AAO

First Identified: October 2012

2019 est Medicare Utilization: 373

2021 Work RVU: 17.40

2021 NF PE RVU: NA

2021 Fac PE RVU: 16.10

RUC Recommendation: 17.40

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

67101 **Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy**

Global: 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2015 **2019 est Medicare Utilization:** 343

2021 Work RVU: 3.50
2021 NF PE RVU: 5.95
2021 Fac PE RVU: 4.45

RUC Recommendation: 3.50 **Referred to CPT** May 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67105 **Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation**

Global: 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2015 **2019 est Medicare Utilization:** 3,778

2021 Work RVU: 3.39
2021 NF PE RVU: 4.98
2021 Fac PE RVU: 4.29

RUC Recommendation: 3.84 **Referred to CPT** May 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67107 **Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 623

2021 Work RVU: 16.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.23

RUC Recommendation: 16.00. Reduce 99238 to 0.5 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67108 **Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 16,523

2021 Work RVU: 17.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.93

RUC Recommendation: 17.13 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67110 **Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 2,305

2021 Work RVU: 10.25
2021 NF PE RVU: 14.89
2021 Fac PE RVU: 12.46

RUC Recommendation: 10.25. Remove 99238 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67112 **Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques**

Global: **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO

First Identified: April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67113 **Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 12,384

2021 Work RVU: 19.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.96

RUC Recommendation: 19.00 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67141 **Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; cryotherapy, diathermy**

Global: 090 **Issue:** Retinal Detachment Prophylaxis **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 08 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** January 2020 **2019 est Medicare Utilization:** 1,395

2021 Work RVU: 6.15
2021 NF PE RVU: 8.63
2021 Fac PE RVU: 7.41

RUC Recommendation: 2.53 **Referred to CPT** May 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67145 **Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)**

Global: 090 **Issue:** Retinal Detachment Prophylaxis **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 08 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2019 **2019 est Medicare Utilization:** 31,865

2021 Work RVU: 6.32
2021 NF PE RVU: 8.51
2021 Fac PE RVU: 7.52

RUC Recommendation: 2.53 **Referred to CPT** May 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67210 **Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 56,884

2021 Work RVU: 6.36
2021 NF PE RVU: 8.14
2021 Fac PE RVU: 7.54

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67220 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,636

2021 Work RVU: 6.36
2021 NF PE RVU: 8.62
2021 Fac PE RVU: 7.54

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67225 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)**

Global: ZZZ **Issue:** Photodynamic Therapy of the Eye **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** P **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 168

2021 Work RVU: 0.47
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67228 **Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation**

Global: 010 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 62,152

2021 Work RVU: 4.39
2021 NF PE RVU: 5.16
2021 Fac PE RVU: 4.04

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67255 **Scleral reinforcement (separate procedure); with graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 833

2021 Work RVU: 8.38
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.83

RUC Recommendation: 10.17 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

67311 **Strabismus surgery, recession or resection procedure; 1 horizontal muscle** **Global:** 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 4,955

2021 Work RVU: 7.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.90

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67312 **Strabismus surgery, recession or resection procedure; 2 horizontal muscles** **Global:** 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 1,514

2021 Work RVU: 9.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.47

RUC Recommendation: 9.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67314 **Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 2,533

2021 Work RVU: 8.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.32

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67316 **Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 168

2021 Work RVU: 10.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.62

RUC Recommendation: 10.31 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67318 **Strabismus surgery, any procedure, superior oblique muscle**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 205

2021 Work RVU: 9.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.86

RUC Recommendation: 9.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67320 **Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 362

2021 Work RVU: 5.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.31

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67331 **Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 902

2021 Work RVU: 5.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67332 **Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,753

2021 Work RVU: 5.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.41

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67334 **Strabismus surgery by posterior fixation suture technique, with or without muscle recession (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 128

2021 Work RVU: 5.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.11

RUC Recommendation: 2.06 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67335 **Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (List separately in addition to code for specific strabismus surgery)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,681

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.52

RUC Recommendation: 3.23 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

67340 **Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 88

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.71

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67500 **Retrobulbar injection; medication (separate procedure, does not include supply of medication)**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2017 **2019 est Medicare Utilization:** 7,903

2021 Work RVU: 1.18
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.52

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67505 **Retrobulbar injection; alcohol**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2017 **2019 est Medicare Utilization:** 140

2021 Work RVU: 1.18
2021 NF PE RVU: 1.26
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67515 **Injection of medication or other substance into Tenon's capsule**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** July 2016 **2019 est Medicare Utilization:** 24,360

2021 Work RVU: 0.75
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.56

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67820 **Correction of trichiasis; epilation, by forceps only**

Global: 000 **Issue:** Correction of Trichiasis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 29 **Specialty Developing Recommendation:** AOA, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 222,157

2021 Work RVU: 0.32
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67914 **Repair of ectropion; suture**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 1,601

2021 Work RVU: 3.75
2021 NF PE RVU: 10.51
2021 Fac PE RVU: 5.40

RUC Recommendation: 3.75

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

67915 **Repair of ectropion; thermocauterization**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 332

2021 Work RVU: 2.03
2021 NF PE RVU: 7.26
2021 Fac PE RVU: 3.54

RUC Recommendation: 2.03

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67916 **Repair of ectropion; excision tarsal wedge**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 1,895

2021 Work RVU: 5.48
2021 NF PE RVU: 12.24
2021 Fac PE RVU: 6.46

RUC Recommendation: 5.48

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 24,678

2021 Work RVU: 5.93
2021 NF PE RVU: 12.07
2021 Fac PE RVU: 6.75

RUC Recommendation: 5.93

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67921 **Repair of entropion; suture**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 3,614

2021 Work RVU: 3.47
2021 NF PE RVU: 10.56
2021 Fac PE RVU: 5.25

RUC Recommendation: 3.47

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

67922 **Repair of entropion; thermocauterization**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 100

2021 Work RVU: 2.03
2021 NF PE RVU: 6.95
2021 Fac PE RVU: 3.52

RUC Recommendation: 2.03

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

67923 **Repair of entropion; excision tarsal wedge**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 1,300

2021 Work RVU: 5.48
2021 NF PE RVU: 12.25
2021 Fac PE RVU: 6.48

RUC Recommendation: 5.48

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67924 **Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2019 est Medicare Utilization: 11,149

2021 Work RVU: 5.93
2021 NF PE RVU: 12.90
2021 Fac PE RVU: 6.76

RUC Recommendation: 5.93

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

68040 **Expression of conjunctival follicles (eg, for trachoma)**

Global: 000 **Issue:** Treatment of Eyelid Lesions **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AAO

First Identified: February 2008

2019 est Medicare Utilization: 6,702

2021 Work RVU: 0.85
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.49

RUC Recommendation: Revised parenthetical

Referred to CPT February 2013

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

68200 **Subconjunctival injection**

Global: 000 **Issue:** Subconjunctival Injection **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO

First Identified: April 2011

2019 est Medicare Utilization: 8,059

2021 Work RVU: 0.49
2021 NF PE RVU: 0.68
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.49

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

68801 **Dilation of lacrimal punctum, with or without irrigation**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: January 2014

2019 est Medicare Utilization: 27,980

2021 Work RVU: 0.82
2021 NF PE RVU: 1.91
2021 Fac PE RVU: 1.39

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

68810 **Probing of nasolacrimal duct, with or without irrigation;**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** Site of Service Anomaly / 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: September 2007

2019 est Medicare Utilization: 28,019

2021 Work RVU: 1.54
2021 NF PE RVU: 3.07
2021 Fac PE RVU: 2.02

RUC Recommendation: 1.54

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

68811 **Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia**

Global: 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: September 2014 **2019 est Medicare Utilization:** 451

2021 Work RVU: 1.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.01

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

68815 **Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: January 2014 **2019 est Medicare Utilization:** 8,129

2021 Work RVU: 2.70
2021 NF PE RVU: 8.61
2021 Fac PE RVU: 3.49

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

68816 **Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation**

Global: 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: September 2014 **2019 est Medicare Utilization:** 248

2021 Work RVU: 2.10
2021 NF PE RVU: 23.29
2021 Fac PE RVU: 2.26

RUC Recommendation: 2.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

69100 **Biopsy external ear**

Global: 000 **Issue:** Biopsy of Ear **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 28 **Specialty Developing Recommendation:** AAD

First Identified: October 2008 **2019 est Medicare Utilization:** 164,973

2021 Work RVU: 0.81
2021 NF PE RVU: 2.01
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.81 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69200 **Removal foreign body from external auditory canal; without general anesthesia** **Global:** 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 29 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2011 **2019 est Medicare Utilization:** 59,479

2021 Work RVU: 0.77
2021 NF PE RVU: 1.51
2021 Fac PE RVU: 0.49

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

69210 **Removal impacted cerumen requiring instrumentation, unilateral** **Global:** 000 **Issue:** Removal of Cerumen **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 29 **Specialty Developing Recommendation:** AAFP, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,589,620

2021 Work RVU: 0.61
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.58. **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

69400 **Eustachian tube inflation, transnasal; with catheterization** **Global:** **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

69401 **Eustachian tube inflation, transnasal; without catheterization** **Global:** **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69405 **Eustachian tube catheterization, transtympanic**

Global: **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

69433 **Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia**

Global: 010 **Issue:** Tympanostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 30 **Specialty Developing Recommendation:** AAO-HNS

First Identified: April 2011 **2019 est Medicare Utilization:** 48,248

2021 Work RVU: 1.57
2021 NF PE RVU: 4.15
2021 Fac PE RVU: 2.03

RUC Recommendation: 1.57

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

69801 **Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal**

Global: 000 **Issue:** Labyrinthotomy **Screen:** CMS Fastest Growing / Site of Service Anomaly (99238-Only) / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2007 **2019 est Medicare Utilization:** 24,321

2021 Work RVU: 2.06
2021 NF PE RVU: 4.22
2021 Fac PE RVU: 1.26

RUC Recommendation: Review action plan at RAW Oct 2015. 2.06

Referred to CPT Feb 2010 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2011

Status Report: CMS Requests and Relativity Assessment Issues

69802 **Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy** **Global:** **Issue:** Labryinthotomy **Screen:** CMS Fastest Growing / Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Feburary 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

69930 **Cochlear device implantation, with or without mastoidectomy** **Global:** 090 **Issue:** Cochlear Device Implantation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** M **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,267

2021 Work RVU: 17.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.81

RUC Recommendation: 17.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70030 **Radiologic examination, eye, for detection of foreign body** **Global:** XXX **Issue:** X-Ray of Eye **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 23,756

2021 Work RVU: 0.18
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70100 **Radiologic examination, mandible; partial, less than 4 views** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 20,165

2021 Work RVU: 0.18
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70210 **Radiologic examination, sinuses, paranasal, less than 3 views** **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 24 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 31,748

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.20

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70220 **Radiologic examination, sinuses, paranasal, complete, minimum of 3 views** **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 24 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 59,212

2021 Work RVU: 0.22
2021 NF PE RVU: 0.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.22

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70250 **Radiologic examination, skull; less than 4 views**

Global: XXX **Issue:** X-Ray Exam – Skull **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 25 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 45,019

2021 Work RVU: 0.18
2021 NF PE RVU: 0.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70260 **Radiologic examination, skull; complete, minimum of 4 views**

Global: XXX **Issue:** X-Ray Exam – Skull **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 25 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 9,622

2021 Work RVU: 0.28
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70310 **Radiologic examination, teeth; partial examination, less than full mouth**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,217

2021 Work RVU: 0.16
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70360 **Radiologic examination; neck, soft tissue** **Global:** XXX **Issue:** X-Ray Exam – Neck **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 26 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 64,675

2021 Work RVU: 0.18
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70371 **Complex dynamic pharyngeal and speech evaluation by cine or video recording** **Global:** XXX **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, AAFP **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,976

2021 Work RVU: 0.84
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published, addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

70373 **Laryngography, contrast, radiological supervision and interpretation** **Global:** **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** **Specialty Developing Recommendation:** ACR, AAFP **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: CPT Assistant article published. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

Status Report: CMS Requests and Relativity Assessment Issues

70450 **Computed tomography, head or brain; without contrast material**

Global: XXX **Issue:** CT Head/Brain **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,711,912

2021 Work RVU: 0.85
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70460 **Computed tomography, head or brain; with contrast material(s)**

Global: XXX **Issue:** CT Head/Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 28,050

2021 Work RVU: 1.13
2021 NF PE RVU: 3.49
2021 Fac PE RVU: NA

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70470 **Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Head/Brain **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:** 92,135

2021 Work RVU: 1.27
2021 NF PE RVU: 4.17
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70480 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 54,791

2021 Work RVU: 1.28
2021 NF PE RVU: 3.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70481 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 10,929

2021 Work RVU: 1.13
2021 NF PE RVU: 4.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70482 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 4,917

2021 Work RVU: 1.27
2021 NF PE RVU: 5.42
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70486 **Computed tomography, maxillofacial area; without contrast material**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 532,110

2021 Work RVU: 0.85
2021 NF PE RVU: 3.13
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70487 **Computed tomography, maxillofacial area; with contrast material(s)**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 30,559

2021 Work RVU: 1.13
2021 NF PE RVU: 3.62
2021 Fac PE RVU: NA

RUC Recommendation: 1.17 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70488 **Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 3,505

2021 Work RVU: 1.27
2021 NF PE RVU: 4.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70490 **Computed tomography, soft tissue neck; without contrast material**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 68,230

2021 Work RVU: 1.28
2021 NF PE RVU: 3.38
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70491 **Computed tomography, soft tissue neck; with contrast material(s)**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 279,888

2021 Work RVU: 1.38
2021 NF PE RVU: 4.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.38 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70492 **Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 25,867

2021 Work RVU: 1.62
2021 NF PE RVU: 5.37
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70496 **Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography – Head & Neck **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2019 est Medicare Utilization:** 525,192

2021 Work RVU: 1.75
2021 NF PE RVU: 6.80
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70498 **Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography – Head & Neck **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2019 est Medicare Utilization:** 546,880

2021 Work RVU: 1.75
2021 NF PE RVU: 6.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70540 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 10,325

2021 Work RVU: 1.35
2021 NF PE RVU: 6.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70542 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 993

2021 Work RVU: 1.62
2021 NF PE RVU: 7.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70543 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 61,843

2021 Work RVU: 2.15
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70544 **Magnetic resonance angiography, head; without contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 247,119

2021 Work RVU: 1.20
2021 NF PE RVU: 5.71
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70545 **Magnetic resonance angiography, head; with contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 3,638

2021 Work RVU: 1.20
2021 NF PE RVU: 6.08
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70546 **Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 18,220

2021 Work RVU: 1.48
2021 NF PE RVU: 9.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70547 **Magnetic resonance angiography, neck; without contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 78,876

2021 Work RVU: 1.20
2021 NF PE RVU: 5.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70548 **Magnetic resonance angiography, neck; with contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 17,524

2021 Work RVU: 1.50
2021 NF PE RVU: 6.32
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70549 **Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 58,959

2021 Work RVU: 1.80
2021 NF PE RVU: 9.27
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70551 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,166,152

2021 Work RVU: 1.48
2021 NF PE RVU: 4.76
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70552 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,951

2021 Work RVU: 1.78
2021 NF PE RVU: 6.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70553 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,005,264

2021 Work RVU: 2.29
2021 NF PE RVU: 7.97
2021 Fac PE RVU: NA

RUC Recommendation: 2.36 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71010 **Radiologic examination, chest; single view, frontal**

Global: **Issue:** Chest X-Rays **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71015 **Radiologic examination, chest; stereo, frontal**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71020 **Radiologic examination, chest, 2 views, frontal and lateral;** **Global:** **Issue:** Chest X-Rays **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71021 **Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71022 **Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71023 **Radiologic examination, chest, 2 views, frontal and lateral; with fluoroscopy** **Global:** **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71030 **Radiologic examination, chest, complete, minimum of 4 views;** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71034 **Radiologic examination, chest, complete, minimum of 4 views; with fluoroscopy** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71035 **Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71045 **Radiologic examination, chest; single view** **Global:** XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2019 est Medicare Utilization:** 15,582,853

2021 Work RVU: 0.18
2021 NF PE RVU: 0.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71046 **Radiologic examination, chest; 2 views** **Global:** XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2019 est Medicare Utilization:** 10,465,557

2021 Work RVU: 0.22
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71047 **Radiologic examination, chest; 3 views** **Global:** XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2019 est Medicare Utilization:** 15,324

2021 Work RVU: 0.27
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71048 **Radiologic examination, chest; 4 or more views** **Global:** XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2019 est Medicare Utilization:** 10,897

2021 Work RVU: 0.31
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71090 **Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation**

Global: **Issue:** Insertion/Removal of Pacemeaker or Pacing Cardioverter-Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71100 **Radiologic examination, ribs, unilateral; 2 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 174,554

2021 Work RVU: 0.22
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71101 **Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 301,474

2021 Work RVU: 0.27
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71110 **Radiologic examination, ribs, bilateral; 3 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR

First Identified: October 2015 **2019 est Medicare Utilization:** 24,795

2021 Work RVU: 0.29
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71111 **Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR

First Identified: October 2015 **2019 est Medicare Utilization:** 30,595

2021 Work RVU: 0.32
2021 NF PE RVU: 1.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71250 **Computed tomography, thorax, diagnostic; without contrast material**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: October 2008 **2019 est Medicare Utilization:** 2,320,224

2021 Work RVU: 1.08
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71260 **Computed tomography, thorax, diagnostic; with contrast material(s)** **Global:** XXX **Issue:** Screening CT of Thorax **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,835,534

2021 Work RVU: 1.16
2021 NF PE RVU: 4.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.38 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

71270 **Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** Screening CT of Thorax **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 70,977

2021 Work RVU: 1.25
2021 NF PE RVU: 4.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

71271 **Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)** **Global:** XXX **Issue:** Screening CT of Thorax **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** **First Identified:** May 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.08
2021 NF PE RVU: 3.18
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71275 **Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography-Chest **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 27 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,282,747

2021 Work RVU: 1.82
2021 NF PE RVU: 6.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

72020 **Radiologic examination, spine, single view, specify level**

Global: XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2019 est Medicare Utilization:** 145,820

2021 Work RVU: 0.16
2021 NF PE RVU: 0.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72040 **Radiologic examination, spine, cervical; 2 or 3 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 641,468

2021 Work RVU: 0.22
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72050 **Radiologic examination, spine, cervical; 4 or 5 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 378,821

2021 Work RVU: 0.27
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72052 **Radiologic examination, spine, cervical; 6 or more views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 80,862

2021 Work RVU: 0.30
2021 NF PE RVU: 1.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72070 **Radiologic examination, spine; thoracic, 2 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 300,255

2021 Work RVU: 0.20
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72072 **Radiologic examination, spine; thoracic, 3 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2019 est Medicare Utilization:** 184,802

2021 Work RVU: 0.23
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.23 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72074 **Radiologic examination, spine; thoracic, minimum of 4 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2016 **2019 est Medicare Utilization:** 12,934

2021 Work RVU: 0.25
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72080 **Radiologic examination, spine; thoracolumbar junction, minimum of 2 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2016 **2019 est Medicare Utilization:** 46,745

2021 Work RVU: 0.21
2021 NF PE RVU: 0.78
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72100 **Radiologic examination, spine, lumbosacral; 2 or 3 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,818,987

2021 Work RVU: 0.22
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72110 **Radiologic examination, spine, lumbosacral; minimum of 4 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:** 821,121

2021 Work RVU: 0.26
2021 NF PE RVU: 1.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

72114 **Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 96,261

2021 Work RVU: 0.30
2021 NF PE RVU: 1.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72120 **Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 52,798

2021 Work RVU: 0.22
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72125 **Computed tomography, cervical spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,308,607

2021 Work RVU: 1.00
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.07 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72126 **Computed tomography, cervical spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 20,553

2021 Work RVU: 1.22
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72127 **Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,798

2021 Work RVU: 1.27
2021 NF PE RVU: 4.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72128 **Computed tomography, thoracic spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2019 est Medicare Utilization:** 199,533

2021 Work RVU: 1.00
2021 NF PE RVU: 3.03
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72129 **Computed tomography, thoracic spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 26,437

2021 Work RVU: 1.22
2021 NF PE RVU: 4.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72130 **Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,318

2021 Work RVU: 1.27
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72131 **Computed tomography, lumbar spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 519,043

2021 Work RVU: 1.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72132 **Computed tomography, lumbar spine; with contrast material**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,654

2021 Work RVU: 1.22
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72133 **Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 4,078

2021 Work RVU: 1.27
2021 NF PE RVU: 4.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72141 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** September 2011 **2019 est Medicare Utilization:** 600,156

2021 Work RVU: 1.48
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,391

2021 Work RVU: 1.78
2021 NF PE RVU: 7.12
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 223,500

2021 Work RVU: 1.48
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72147 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,124

2021 Work RVU: 1.78
2021 NF PE RVU: 7.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72148 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, AUR, ACR, NASS, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,346,832

2021 Work RVU: 1.48
2021 NF PE RVU: 4.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72149 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 5,622

2021 Work RVU: 1.78
2021 NF PE RVU: 6.98
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72156 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 120,879

2021 Work RVU: 2.29
2021 NF PE RVU: 8.07
2021 Fac PE RVU: NA

RUC Recommendation: 2.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72157 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 98,889

2021 Work RVU: 2.29
2021 NF PE RVU: 8.09
2021 Fac PE RVU: NA

RUC Recommendation: 2.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

72158 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 244,364

2021 Work RVU: 2.29
2021 NF PE RVU: 8.05
2021 Fac PE RVU: NA

RUC Recommendation: 2.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

72170 **Radiologic examination, pelvis; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exam – Pelvis **Screen:** Low Value-High Volume / Codes Reported Together 75% or More-Part2 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 28 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010

2019 est Medicare Utilization: 792,294

2021 Work RVU: 0.17
2021 NF PE RVU: 0.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.17

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72190 **Radiologic examination, pelvis; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Exam – Pelvis **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 28 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 56,338

2021 Work RVU: 0.25
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72191 **Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth1 / CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,441

2021 Work RVU: 1.81
2021 NF PE RVU: 7.69
2021 Fac PE RVU: NA

RUC Recommendation: 1.81 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72192 **Computed tomography, pelvis; without contrast material**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 183,953

2021 Work RVU: 1.09
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.09 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72193 **Computed tomography, pelvis; with contrast material(s)**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 37,206

2021 Work RVU: 1.16
2021 NF PE RVU: 6.05
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72194 **Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen and Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,552

2021 Work RVU: 1.22
2021 NF PE RVU: 6.81
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72195 **Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)**

Global: XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 85,947

2021 Work RVU: 1.46
2021 NF PE RVU: 6.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72196 **Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)**

Global: XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 2,606

2021 Work RVU: 1.73
2021 NF PE RVU: 7.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.73 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72197 **Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 214,192

2021 Work RVU: 2.20
2021 NF PE RVU: 8.83
2021 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72200 **Radiologic examination, sacroiliac joints; less than 3 views**

Global: XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 14,605

2021 Work RVU: 0.17
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72202 **Radiologic examination, sacroiliac joints; 3 or more views**

Global: XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 39,418

2021 Work RVU: 0.23
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72220 **Radiologic examination, sacrum and coccyx, minimum of 2 views**

Global: XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2016 **2019 est Medicare Utilization:** 116,528

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72240 **Myelography, cervical, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 647

2021 Work RVU: 0.91
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.91 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72255 **Myelography, thoracic, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2013 **2019 est Medicare Utilization:** 125

2021 Work RVU: 0.91
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.91 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72265 **Myelography, lumbosacral, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,681

2021 Work RVU: 0.83
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72270 **Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,087

2021 Work RVU: 1.33
2021 NF PE RVU: 2.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.33 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72275 **Epidurography, radiological supervision and interpretation**

Global: XXX **Issue:** Epidurography **Screen:** Different Performing Specialty from Survey3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS **First Identified:** October 2009 **2019 est Medicare Utilization:** 66,516

2021 Work RVU: 0.76
2021 NF PE RVU: 3.29
2021 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009 and Q&A - May 2010

Status Report: CMS Requests and Relativity Assessment Issues

72291 **Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance**

Global: **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

72292 **Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance**

Global: **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73000 **Radiologic examination; clavicle, complete**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS

First Identified: October 2017 **2019 est Medicare Utilization:** 100,682

2021 Work RVU: 0.16
2021 NF PE RVU: 0.76
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73010 **Radiologic examination; scapula, complete** **Global:** XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 51,052

2021 Work RVU: 0.17
2021 NF PE RVU: 0.50
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73020 **Radiologic examination, shoulder; 1 view** **Global:** XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 119,144

2021 Work RVU: 0.15
2021 NF PE RVU: 0.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73030 **Radiologic examination, shoulder; complete, minimum of 2 views** **Global:** XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** Low Value-High Volume / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,765,924

2021 Work RVU: 0.18
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73050 **Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 8,123

2021 Work RVU: 0.18
2021 NF PE RVU: 0.63
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73060 **Radiologic examination; humerus, minimum of 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 341,436

2021 Work RVU: 0.16
2021 NF PE RVU: 0.76
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73070 **Radiologic examination, elbow; 2 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2019 est Medicare Utilization:** 219,794

2021 Work RVU: 0.16
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73080 **Radiologic examination, elbow; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** October 2009 **2019 est Medicare Utilization:** 404,093

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73090 **Radiologic examination; forearm, 2 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2019 est Medicare Utilization:** 230,897

2021 Work RVU: 0.16
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73100 **Radiologic examination, wrist; 2 views**

Global: XXX **Issue:** X-Ray Wrist **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 32 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 274,134

2021 Work RVU: 0.16
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73110 **Radiologic examination, wrist; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Wrist **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 32 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,064,258

2021 Work RVU: 0.17
2021 NF PE RVU: 0.99
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73120 **Radiologic examination, hand; 2 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2019 est Medicare Utilization:** 278,753

2021 Work RVU: 0.16
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73130 **Radiologic examination, hand; minimum of 3 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,282,863

2021 Work RVU: 0.17
2021 NF PE RVU: 0.87
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73140 **Radiologic examination, finger(s), minimum of 2 views** **Global:** XXX **Issue:** X-Ray of Hand/Fingers **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 388,288

2021 Work RVU: 0.13
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.13 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73200 **Computed tomography, upper extremity; without contrast material** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 23 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 126,320

2021 Work RVU: 1.00
2021 NF PE RVU: 4.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.09 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

73201 **Computed tomography, upper extremity; with contrast material(s)** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 21,360

2021 Work RVU: 1.16
2021 NF PE RVU: 5.25
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

73202 **Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,982

2021 Work RVU: 1.22
2021 NF PE RVU: 6.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73206 **Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** May 2013 **2019 est Medicare Utilization:** 6,543

2021 Work RVU: 1.81
2021 NF PE RVU: 7.60
2021 Fac PE RVU: NA

RUC Recommendation: Survey with all CTA codes for October 2013.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

73218 **Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 33,624

2021 Work RVU: 1.35
2021 NF PE RVU: 8.72
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2011

Result: Maintain

73221 **Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 475,051

2021 Work RVU: 1.35
2021 NF PE RVU: 5.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

73500 **Radiologic examination, hip, unilateral; 1 view**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73501 **Radiologic examination, hip, unilateral, with pelvis when performed; 1 view**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 285,022

2021 Work RVU: 0.18
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73502 **Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 2,694,536

2021 Work RVU: 0.22
2021 NF PE RVU: 1.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73503 **Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 46,804

2021 Work RVU: 0.27
2021 NF PE RVU: 1.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73510 **Radiologic examination, hip, unilateral; complete, minimum of 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73520 **Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73521 **Radiologic examination, hips, bilateral, with pelvis when performed; 2 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 158,149

2021 Work RVU: 0.22
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73522 **Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 188,143

2021 Work RVU: 0.29
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73523 **Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 107,476

2021 Work RVU: 0.31
2021 NF PE RVU: 1.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73540 **Radiologic examination, pelvis and hips, infant or child, minimum of 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73542 **Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation**

Global: **Issue:** Sacroiliac Joint Arthrography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS, ACR, AUR, ISIS, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT

73550 **Radiologic examination, femur, 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73551 **Radiologic examination, femur; 1 view**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2014 **2019 est Medicare Utilization:** 37,871

2021 Work RVU: 0.16
2021 NF PE RVU: 0.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.16

Referred to CPT October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73552 **Radiologic examination, femur; minimum 2 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2014 **2019 est Medicare Utilization:** 548,327

2021 Work RVU: 0.18
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.18

Referred to CPT October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73560 **Radiologic examination, knee; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,784,814

2021 Work RVU: 0.16
2021 NF PE RVU: 0.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.16

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73562 **Radiologic examination, knee; 3 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 2,516,006

2021 Work RVU: 0.18
2021 NF PE RVU: 0.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.18

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73564 **Radiologic examination, knee; complete, 4 or more views** **Global:** XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,648,754

2021 Work RVU: 0.22
2021 NF PE RVU: 1.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73565 **Radiologic examination, knee; both knees, standing, anteroposterior** **Global:** XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 207,121

2021 Work RVU: 0.16
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73580 **Radiologic examination, knee, arthrography, radiological supervision and interpretation** **Global:** XXX **Issue:** Contrast X-Ray of Knee Joint **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 30,453

2021 Work RVU: 0.54
2021 NF PE RVU: 3.68
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** May 2021 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2012

Status Report: CMS Requests and Relativity Assessment Issues

73590 **Radiologic examination; tibia and fibula, 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 500,593

2021 Work RVU: 0.16
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73600 **Radiologic examination, ankle; 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR, APMA **First Identified:** April 2013 **2019 est Medicare Utilization:** 240,693

2021 Work RVU: 0.16
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73610 **Radiologic examination, ankle; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,281,503

2021 Work RVU: 0.17
2021 NF PE RVU: 0.88
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73620 **Radiologic examination, foot; 2 views**

Global: XXX **Issue:** X-Ray Exam of Foot **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACR, AAOS, APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 574,129

2021 Work RVU: 0.16
2021 NF PE RVU: 0.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73630 **Radiologic examination, foot; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2019 est Medicare Utilization:** 2,820,181

2021 Work RVU: 0.17
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73650 **Radiologic examination; calcaneus, minimum of 2 views**

Global: XXX **Issue:** X-Ray Heel **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 31 **Specialty Developing Recommendation:** AAOS, ACR, APMA, AOFAS **First Identified:** April 2016 **2019 est Medicare Utilization:** 81,836

2021 Work RVU: 0.16
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73660 **Radiologic examination; toe(s), minimum of 2 views**

Global: XXX **Issue:** X-Ray Toe **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 32 **Specialty Developing Recommendation:** AAOS, ACR, APMA, AOFAS **First Identified:** April 2016 **2019 est Medicare Utilization:** 120,091

2021 Work RVU: 0.13
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73700 **Computed tomography, lower extremity; without contrast material**

Global: XXX **Issue:** CT Lower Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 338,278

2021 Work RVU: 1.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73701 **Computed tomography, lower extremity; with contrast material(s)**

Global: XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth1 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 47,637

2021 Work RVU: 1.16
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73702 **Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 4,842

2021 Work RVU: 1.22
2021 NF PE RVU: 4.88
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73706 **Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:** 16,508

2021 Work RVU: 1.90
2021 NF PE RVU: 8.30
2021 Fac PE RVU: NA

RUC Recommendation: Survey for October 2013. Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73718 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 148,143

2021 Work RVU: 1.35
2021 NF PE RVU: 5.93
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73719 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,344

2021 Work RVU: 1.62
2021 NF PE RVU: 6.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73720 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 64,864

2021 Work RVU: 2.15
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73721 **Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material**

Global: XXX **Issue:** MRI of Lower Extremity Joint **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 670,662

2021 Work RVU: 1.35
2021 NF PE RVU: 5.11
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74000 **Radiologic examination, abdomen; single anteroposterior view**

Global: **Issue:** Abdominal X-Ray **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74010 **Radiologic examination, abdomen; anteroposterior and additional oblique and cone views**

Global: **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74018 **Radiologic examination, abdomen; 1 view**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2019 est Medicare Utilization:** 2,153,087

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74019 **Radiologic examination, abdomen; 2 views**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2019 est Medicare Utilization:** 429,437

2021 Work RVU: 0.23
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.23 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74020 **Radiologic examination, abdomen; complete, including decubitus and/or erect views**

Global: **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74021 **Radiologic examination, abdomen; 3 or more views**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2019 est Medicare Utilization:** 58,811

2021 Work RVU: 0.27
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74022 **Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: July 2015

2019 est Medicare Utilization: 283,318

2021 Work RVU: 0.32
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.32

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

74150 **Computed tomography, abdomen; without contrast material**

Global: XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACR

First Identified: February 2008

2019 est Medicare Utilization: 77,343

2021 Work RVU: 1.19
2021 NF PE RVU: 3.05
2021 Fac PE RVU: NA

RUC Recommendation: Review PE. 0.35

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

74160 **Computed tomography, abdomen; with contrast material(s)**

Global: XXX **Issue:** CT Abdomen and Pelvis **Screen:** Codes Reported Together 95% or More / MPC List / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR

First Identified: February 2008

2019 est Medicare Utilization: 105,409

2021 Work RVU: 1.27
2021 NF PE RVU: 6.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.42

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

74170 **Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 34 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 107,476

2021 Work RVU: 1.40
2021 NF PE RVU: 6.85
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74174 **Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** **2019 est Medicare Utilization:** 294,980

2021 Work RVU: 2.20
2021 NF PE RVU: 9.64
2021 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74175 **Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 37,638

2021 Work RVU: 1.82
2021 NF PE RVU: 7.68
2021 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74176 **Computed tomography, abdomen and pelvis; without contrast material** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 16 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,284,436

2021 Work RVU: 1.74
2021 NF PE RVU: 3.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74177 **Computed tomography, abdomen and pelvis; with contrast material(s)** **Global:** XXX **Issue:** CT Abdomen and Pelvis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,361,910

2021 Work RVU: 1.82
2021 NF PE RVU: 7.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74178 **Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 16 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 534,971

2021 Work RVU: 2.01
2021 NF PE RVU: 8.78
2021 Fac PE RVU: NA

RUC Recommendation: 2.01 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74181 **Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 117,420

2021 Work RVU: 1.46
2021 NF PE RVU: 4.86
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74182 **Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 4,286

2021 Work RVU: 1.73
2021 NF PE RVU: 8.19
2021 Fac PE RVU: NA

RUC Recommendation: 1.73 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74183 **Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 354,840

2021 Work RVU: 2.20
2021 NF PE RVU: 8.85
2021 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74210 **Radiologic examination, pharynx and/or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2016 **2019 est Medicare Utilization:** 1,577

2021 Work RVU: 0.59
2021 NF PE RVU: 2.27
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74220 **Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR

First Identified: April 2016 **2019 est Medicare Utilization:** 196,573

2021 Work RVU: 0.60
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74221 **Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.70
2021 NF PE RVU: 2.57
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74230 **Radiologic examination, swallowing function, with cineradiography/videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Esophagus **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 370,056

2021 Work RVU: 0.53
2021 NF PE RVU: 3.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

74240 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 53,309

2021 Work RVU: 0.80
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74241 **Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 25,415

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74245 **Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 12,946

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74246 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 34,438

2021 Work RVU: 0.90
2021 NF PE RVU: 3.26
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74247 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 21,591

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74248 **Radiologic small intestine follow-through study, including multiple serial images (List separately in addition to code for primary procedure for upper GI radiologic examination)**

Global: ZZZ **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.70
2021 NF PE RVU: 1.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** February 2019-EC **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74249 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 13,972

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74250 **Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 52,021

2021 Work RVU: 0.81
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74251 **Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 206

2021 Work RVU: 1.17
2021 NF PE RVU: 10.69
2021 Fac PE RVU: NA

RUC Recommendation: 1.17 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74260 **Duodenography, hypotonic**

Global: **Issue:** X-Ray Exam – Small Intestine/Colon **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 24

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74270 **Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 28,934

2021 Work RVU: 1.04
2021 NF PE RVU: 3.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.04 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74280 **Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,205

2021 Work RVU: 1.26
2021 NF PE RVU: 5.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.26 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74300 **Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 29,648

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74301 **Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ACS, SAGES, SIR **First Identified:** October 2018 **2019 est Medicare Utilization:** 63

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74305 **Deleted from CPT**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74320 **Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74327 **Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74328 **Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 64,506

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74329 **Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 2,990

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74330 **Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 13,859

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74400 **Urography (pyelography), intravenous, with or without KUB, with or without tomography**

Global: XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 31 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,180

2021 Work RVU: 0.49
2021 NF PE RVU: 3.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74420 **Urography, retrograde, with or without KUB**

Global: XXX **Issue:** X-Ray Urinary Tract **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 26 **Specialty Developing Recommendation:** ACR, AUA **First Identified:** April 2016 **2019 est Medicare Utilization:** 166,220

2021 Work RVU: 0.52
2021 NF PE RVU: 1.69
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74425 **Urography, antegrade, radiological supervision and interpretation**

Global: XXX **Issue:** Urography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, AUA, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,703

2021 Work RVU: 0.51
2021 NF PE RVU: 3.53
2021 Fac PE RVU: NA

RUC Recommendation: 0.51, editorially revised **Referred to CPT** September 2019 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74475 **Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74480 **Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74485 **Dilation of ureter(s) or urethra, radiological supervision and interpretation**

Global: XXX **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,628

2021 Work RVU: 0.83
2021 NF PE RVU: 2.63
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75561 **Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 2.60
2021 NF PE RVU: 9.39
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75572 **Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 1.75
2021 NF PE RVU: 6.13
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

75574 **Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** **Screen:** CMS Request - Final Rule for 2013 / High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACR, SIR, ACC **First Identified:** May 2013 **2019 est Medicare Utilization:** 86,531

2021 Work RVU: 2.40
2021 NF PE RVU: 9.10
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

75625 **Aortography, abdominal, by serialography, radiological supervision and interpretation**

Global: XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 96,916

2021 Work RVU: 1.44
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75630 **Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation**

Global: XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 27,465

2021 Work RVU: 2.00
2021 NF PE RVU: 2.62
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** CT Angiography of Abdominal Arteries **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 34 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 114,472

2021 Work RVU: 2.40
2021 NF PE RVU: 10.42
2021 Fac PE RVU: NA

RUC Recommendation: 2.40 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

75650 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75671 **Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75680 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75710 **Angiography, extremity, unilateral, radiological supervision and interpretation**

Global: XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 157,614

2021 Work RVU: 1.75
2021 NF PE RVU: 2.66
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant and review after 2 years of data after publication available. 1.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75716 **Angiography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 74,926

2021 Work RVU: 1.97
2021 NF PE RVU: 2.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75722 **Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation** **Global:** **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75724 **Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation** **Global:** **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75726 **Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation**

Global: XXX **Issue:** Angiography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 20 **Specialty Developing Recommendation:** SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 41,396

2021 Work RVU: 2.05
2021 NF PE RVU: 3.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.05 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75774 **Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Angiography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 20 **Specialty Developing Recommendation:** SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 77,363

2021 Work RVU: 1.01
2021 NF PE RVU: 1.93
2021 Fac PE RVU: NA

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75790 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 9 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75791 **Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75820 **Venography, extremity, unilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 23,689

2021 Work RVU: 1.05
2021 NF PE RVU: 2.30
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75822 **Venography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 10,692

2021 Work RVU: 1.48
2021 NF PE RVU: 2.51
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75885 **Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 348

2021 Work RVU: 1.44
2021 NF PE RVU: 2.64
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

75887 **Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 525

2021 Work RVU: 1.44
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

75894 **Transcatheter therapy, embolization, any method, radiological supervision and interpretation**

Global: XXX **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,539

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** RAW will assess Oct 2018 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75896 **Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation**

Global: **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 09 **Specialty Developing Recommendation:** AANS/CNS, ACR, ASNR, SCAI, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 February 2015 May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75898 **Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis**

Global: XXX **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AANS/CNS, ACR, ASNR, SCAI, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,637

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant **Referred to CPT** February 2014 February 2015 **Result:** Contractor Price

Referred to CPT Asst ☑ **Published in CPT Asst:** September 2019

75940 **Percutaneous placement of IVC filter, radiological supervision and interpretation**

Global: **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75945 **Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75946 **Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75952 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75953 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75954 **Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75960 **Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel**

Global: **Issue:** RAW **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75961 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation**

Global: **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75962 **Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75964 **Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75966 **Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** January 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75968 **Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** January 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75978 **Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75980 **Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75982 **Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75984 **Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation**

Global: XXX **Issue:** Introduction of Catheter or Stent **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 20,664

2021 Work RVU: 0.83
2021 NF PE RVU: 2.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** RAW will assess Oct 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75992 **Deleted from CPT** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75993 **Deleted from CPT** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75994 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75995 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75996 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76000 **Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time** **Global:** XXX **Issue:** Fluoroscopy **Screen:** Low Value-Billed in Multiple Units / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 27 **Specialty Developing Recommendation:** ACR, APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 118,492

2021 Work RVU: 0.30
2021 NF PE RVU: 0.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76001 **Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)** **Global:** **Issue:** Fluoroscopy **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 27 **Specialty Developing Recommendation:** ACR **First Identified:** October 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76098 **Radiological examination, surgical specimen** **Global:** XXX **Issue:** X-Ray Exam Specimen **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 68,182

2021 Work RVU: 0.31
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76100 **Radiologic examination, single plane body section (eg, tomography), other than with urography** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 5,269

2021 Work RVU: 0.58
2021 NF PE RVU: 2.12
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

76101 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 2

2021 Work RVU: 0.58
2021 NF PE RVU: 2.30
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

76102 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 2,408

2021 Work RVU: 0.58
2021 NF PE RVU: 4.65
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76376 **3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation**

Global: XXX **Issue:** 3D Rendering **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 23 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2017 **2019 est Medicare Utilization:** 276,317

2021 Work RVU: 0.20
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76377 **3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation**

Global: XXX **Issue:** 3D Rendering with Interpretation and Report **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 30 **Specialty Developing Recommendation:** ACR, ASNR, SIR **First Identified:** July 2019 **2019 est Medicare Utilization:** 190,343

2021 Work RVU: 0.79
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** May 2021 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

76510 **Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter**

Global: XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 14,435

2021 Work RVU: 0.70
2021 NF PE RVU: 1.41
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76511 **Ophthalmic ultrasound, diagnostic; quantitative A-scan only** **Global:** XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 4,208

2021 Work RVU: 0.64
2021 NF PE RVU: 1.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.64 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76512 **Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)** **Global:** XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 220,526

2021 Work RVU: 0.56
2021 NF PE RVU: 0.85
2021 Fac PE RVU: NA

RUC Recommendation: 0.56 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76513 **Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral** **Global:** XXX **Issue:** Ophthalmic Ultrasound Anterior Segment **Screen:** High Volume Growth1 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 17 **Specialty Developing Recommendation:** AAO, AOA (optometric), ASCRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 26,263

2021 Work RVU: 0.60
2021 NF PE RVU: 1.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 and CPT Assistant article published **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2013

Status Report: CMS Requests and Relativity Assessment Issues

76514 **Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)**

Global: XXX **Issue:** Echo Exam of Eye Thickness **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 12 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2017 **2019 est Medicare Utilization:** 488,963

2021 Work RVU: 0.14
2021 NF PE RVU: 0.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76516 **Ophthalmic biometry by ultrasound echography, A-scan;**

Global: XXX **Issue:** Opthalmic Biometry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,403

2021 Work RVU: 0.40
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76519 **Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation**

Global: XXX **Issue:** Opthalmic Biometry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 187,253

2021 Work RVU: 0.54
2021 NF PE RVU: 1.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76536 **Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation**

Global: XXX **Issue:** Soft Tissue Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** ACR, ASNR, TES, AACE **First Identified:** October 2008 **2019 est Medicare Utilization:** 945,181

2021 Work RVU: 0.56
2021 NF PE RVU: 2.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76604 **Ultrasound, chest (includes mediastinum), real time with image documentation** **Global:** XXX **Issue:** Ultrasound Exam - Chest **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 24 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 106,091

2021 Work RVU: 0.59
2021 NF PE RVU: 1.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76641 **Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete** **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:** 647,984

2021 Work RVU: 0.73
2021 NF PE RVU: 2.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** October 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76642 **Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited** **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:** 769,119

2021 Work RVU: 0.68
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.68 **Referred to CPT** October 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76645 **Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation** **Global:** **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76700 **Ultrasound, abdominal, real time with image documentation; complete** **Global:** XXX **Issue:** Ultrasound **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 908,859

2021 Work RVU: 0.81
2021 NF PE RVU: 2.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76705 **Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)** **Global:** XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,100,059

2021 Work RVU: 0.59
2021 NF PE RVU: 2.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76706 **Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)** **Global:** XXX **Issue:** Abdominal Aorta Ultrasound Screening **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** May 2015 **2019 est Medicare Utilization:** 159,273

2021 Work RVU: 0.55
2021 NF PE RVU: 2.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2017

76770 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete** **Global:** XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,345,427

2021 Work RVU: 0.74
2021 NF PE RVU: 2.51
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76775 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 522,183

2021 Work RVU: 0.58
2021 NF PE RVU: 1.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.58 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76819 **Fetal biophysical profile; without non-stress testing**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 12,225

2021 Work RVU: 0.77
2021 NF PE RVU: 1.71
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

76830 **Ultrasound, transvaginal**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 442,342

2021 Work RVU: 0.69
2021 NF PE RVU: 2.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76856 **Ultrasound, pelvic (nonobstetric), real time with image documentation;**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 429,962

2021 Work RVU: 0.69
2021 NF PE RVU: 2.48
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76857 **Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 205,984

2021 Work RVU: 0.50
2021 NF PE RVU: 0.87
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76870 **Ultrasound, scrotum and contents**

Global: XXX **Issue:** Ultrasound Exam - Scrotum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 28 **Specialty Developing Recommendation:** ACR, AUA **First Identified:** April 2016 **2019 est Medicare Utilization:** 147,467

2021 Work RVU: 0.64
2021 NF PE RVU: 2.39
2021 Fac PE RVU: NA

RUC Recommendation: 0.64 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76872 **Ultrasound, transrectal;**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 212,765

2021 Work RVU: 0.69
2021 NF PE RVU: 4.79
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76880 **Deleted from CPT**

Global: **Issue:** Lower Extremity Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 26 **Specialty Developing Recommendation:** APMA, ACR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76881 **Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation**

Global: XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR, ACRh, APMA **First Identified:** April 2010 **2019 est Medicare Utilization:** 196,753

2021 Work RVU: 0.63
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: Revised PE. RAW review in Oct 2021 **Referred to CPT** June 2017 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Winter 2011; Apr 2016

76882 **Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation**

Global: XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR, ACRh, APMA **First Identified:** April 2010 **2019 est Medicare Utilization:** 288,120

2021 Work RVU: 0.49
2021 NF PE RVU: 1.13
2021 Fac PE RVU: NA

RUC Recommendation: Revised PE. RAW review in Oct 2021 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Summer and Winter 2011; Apr 2016

76930 **Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** July 2013 **2019 est Medicare Utilization:** 2,662

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76932 **Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation**

Global: YYY **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 34 **Specialty Developing Recommendation:** ACC **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,241

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76936 **Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)**

Global: XXX **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** July 2013 **2019 est Medicare Utilization:** 810

2021 Work RVU: 1.99
2021 NF PE RVU: 5.68
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76937 **Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2019 est Medicare Utilization:** 637,782

2021 Work RVU: 0.30
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: Review in 2 years (Oct 2021) **Referred to CPT** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76940 **Ultrasound guidance for, and monitoring of, parenchymal tissue ablation** **Global:** YYY **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 29 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,403

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76942 **Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation** **Global:** XXX **Issue:** Ultrasound Guidance for Needle Placement **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: April 2014 **Tab:** 35 **Specialty Developing Recommendation:** AACE, AAOS, AAPMR, ACR, ACRh, APMA, ASA, ASBS, ASIPP, AUA, SIR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,178,266

2021 Work RVU: 0.67
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT. 0.67 **Referred to CPT** May 2021 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76948 **Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation** **Global:** XXX **Issue:** Echo Guidance for Ova Aspiration **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 25 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2013 **2019 est Medicare Utilization:** 3

2021 Work RVU: 0.67
2021 NF PE RVU: 1.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76950 **Ultrasonic guidance for placement of radiation therapy fields**

Global: **Issue:** Ultrasound Guidance **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 34 **Specialty Developing Recommendation:** **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

76965 **Ultrasonic guidance for interstitial radioelement application**

Global: XXX **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** NO INTERESET **First Identified:** July 2013 **2019 est Medicare Utilization:** 6,316

2021 Work RVU: 1.34
2021 NF PE RVU: 1.31
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76970 **Ultrasound study follow-up (specify)**

Global: XXX **Issue:** IMRT with Ultrasound Guidance **Screen:** High Volume Growth1 / CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACS, ACR, AACE **First Identified:** February 2008 **2019 est Medicare Utilization:** 25,085

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76998 **Ultrasonic guidance, intraoperative**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS **First Identified:** January 2019 **2019 est Medicare Utilization:** 29,381

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** PICC Line Procedures **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** January 2012 **2019 est Medicare Utilization:** 310,854

2021 Work RVU: 0.38
2021 NF PE RVU: 2.58
2021 Fac PE RVU: NA

RUC Recommendation: 0.38 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77002 **Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2015 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 13 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** January 2012 **2019 est Medicare Utilization:** 528,759

2021 Work RVU: 0.54
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77003 **Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 13 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** October 2010 **2019 est Medicare Utilization:** 77,998

2021 Work RVU: 0.60
2021 NF PE RVU: 2.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77011 **Computed tomography guidance for stereotactic localization**

Global: XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 15 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** **2019 est Medicare Utilization:** 4,582

2021 Work RVU: 1.21
2021 NF PE RVU: 5.59
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77012 **Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation**

Global: XXX **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** CMS-Other - Utilization over 100,000 / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** April 2016 **2019 est Medicare Utilization:** 210,656

2021 Work RVU: 1.50
2021 NF PE RVU: 2.73
2021 Fac PE RVU: NA

RUC Recommendation: Bundled 32405 and 77012. 1.50 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77014 **Computed tomography guidance for placement of radiation therapy fields** **Global:** XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** ASTRO, ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,401,373

2021 Work RVU: 0.85
2021 NF PE RVU: 2.72
2021 Fac PE RVU: NA

RUC Recommendation: Referred to CPT, but CMS has not addressed. RAW review action plan (Oct 2021).

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

77031 **Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation** **Global:** **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77032 **Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation** **Global:** **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77046 **Magnetic resonance imaging, breast, without contrast material; unilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 367

2021 Work RVU: 1.45
2021 NF PE RVU: 5.44
2021 Fac PE RVU: NA

RUC Recommendation: 1.45

Referred to CPT June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77047 **Magnetic resonance imaging, breast, without contrast material; bilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 4,029

2021 Work RVU: 1.60
2021 NF PE RVU: 5.48
2021 Fac PE RVU: NA

RUC Recommendation: 1.60

Referred to CPT June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77048 **Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 1,164

2021 Work RVU: 2.10
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.10

Referred to CPT June 2017 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77049 **Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 87,710

2021 Work RVU: 2.30
2021 NF PE RVU: 8.91
2021 Fac PE RVU: NA

RUC Recommendation: 2.30

Referred to CPT June 2017 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

77051 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR

First Identified:

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77052 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR

First Identified: October 2010

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77055 **Mammography; unilateral**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77056 **Mammography; bilateral**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77057 **Screening mammography, bilateral (2-view study of each breast)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77058 **Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral**

Global: **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77059 **Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral**

Global: **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77065 **Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 765,901

2021 Work RVU: 0.81
2021 NF PE RVU: 2.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** October 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

77066 **Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 612,243

2021 Work RVU: 1.00
2021 NF PE RVU: 3.70
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77067 **Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,106,768

2021 Work RVU: 0.76
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 0.76 **Referred to CPT** October 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77073 **Bone length studies (orthoroentgenogram, scanogram)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 57,827

2021 Work RVU: 0.26
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77074 **Radiologic examination, osseous survey; limited (eg, for metastases)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 4,891

2021 Work RVU: 0.44
2021 NF PE RVU: 1.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.44 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77075 **Radiologic examination, osseous survey; complete (axial and appendicular skeleton)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 44,120

2021 Work RVU: 0.55
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77076 **Radiologic examination, osseous survey, infant**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 50

2021 Work RVU: 0.70
2021 NF PE RVU: 2.36
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77077 **Joint survey, single view, 2 or more joints (specify)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 39,322

2021 Work RVU: 0.33
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.33 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

77079 **Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: **Issue:** CT Bone Density Study **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACR, AAFP, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77080 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,624,321

2021 Work RVU: 0.20
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77081 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: XXX **Issue:** Dual-energy X-Ray Absorptiometry (DXA) **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 42,987

2021 Work RVU: 0.20
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77082 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment**

Global: **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77083 **Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites**

Global: **Issue:** Radiographic Absorptiometry **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACR, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77085 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** **2019 est Medicare Utilization:** 110,730

2021 Work RVU: 0.30
2021 NF PE RVU: 1.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77086 **Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** **2019 est Medicare Utilization:** 1,925

2021 Work RVU: 0.17
2021 NF PE RVU: 0.79
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** May 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77261 **Therapeutic radiology treatment planning; simple**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 9,135

2021 Work RVU: 1.30
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.67

RUC Recommendation: 1.30

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77262 **Therapeutic radiology treatment planning; intermediate**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 3,526

2021 Work RVU: 2.00
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.00

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77263 **Therapeutic radiology treatment planning; complex**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO

First Identified: July 2015

2019 est Medicare Utilization: 297,484

2021 Work RVU: 3.14
2021 NF PE RVU: 1.51
2021 Fac PE RVU: 1.51

RUC Recommendation: 3.14

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77280 **Therapeutic radiology simulation-aided field setting; simple**

Global: XXX **Issue:** Set Radiation Therapy Field **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2011 **2019 est Medicare Utilization:** 370,105

2021 Work RVU: 0.70
2021 NF PE RVU: 7.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77285 **Therapeutic radiology simulation-aided field setting; intermediate**

Global: XXX **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,612

2021 Work RVU: 1.05
2021 NF PE RVU: 12.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77290 **Therapeutic radiology simulation-aided field setting; complex**

Global: XXX **Issue:** Respiratory Motion Management Simulation **Screen:** MPC List / Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 210,211

2021 Work RVU: 1.56
2021 NF PE RVU: 12.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.56 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77293 **Respiratory motion management simulation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:** 31,536

2021 Work RVU: 2.00
2021 NF PE RVU: 10.91
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77295 **3-dimensional radiotherapy plan, including dose-volume histograms**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2019 est Medicare Utilization:** 142,124

2021 Work RVU: 4.29
2021 NF PE RVU: 9.58
2021 Fac PE RVU: NA

RUC Recommendation: 4.29 **Referred to CPT** October 2012, October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77300 **Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** MPC List / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,349,820

2021 Work RVU: 0.62
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.62 **Referred to CPT** February 2014, October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77301 **Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications**

Global: XXX **Issue:** IMRT - PE Only **Screen:** CMS Fastest Growing / CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes1 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 28 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:** 143,270

2021 Work RVU: 7.99
2021 NF PE RVU: 46.91
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 7.99. CPT Assistant article published.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009

77305 **Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77306 **Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,027

2021 Work RVU: 1.40
2021 NF PE RVU: 2.84
2021 Fac PE RVU: NA

RUC Recommendation: 1.40

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77307 **Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2010 **2019 est Medicare Utilization:** 40,701

2021 Work RVU: 2.90
2021 NF PE RVU: 5.33
2021 Fac PE RVU: NA

RUC Recommendation: 2.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77310 **Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO

First Identified: October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77315 **Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO

First Identified: October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77316 **Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 4,610

2021 Work RVU: 1.40
2021 NF PE RVU: 5.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77317 **Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 3,179

2021 Work RVU: 1.83
2021 NF PE RVU: 6.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.83 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77318 **Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 / RUC Request **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 5,949

2021 Work RVU: 2.90
2021 NF PE RVU: 9.61
2021 Fac PE RVU: NA

RUC Recommendation: 2.90 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77326 **Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77327 **Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77328 **Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77332 **Treatment devices, design and construction; simple (simple block, simple bolus)**

Global: XXX **Issue:** RAW **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2015 **2019 est Medicare Utilization:** 75,801

2021 Work RVU: 0.45
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77333 **Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)**

Global: XXX **Issue:** RAW **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2015 **2019 est Medicare Utilization:** 12,128

2021 Work RVU: 0.75
2021 NF PE RVU: 3.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77334 **Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)**

Global: XXX **Issue:** **Screen:** MPC List / RUC request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 845,243

2021 Work RVU: 1.15
2021 NF PE RVU: 2.47
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77336 **Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy**

Global: XXX **Issue:** Continuing Medical Physics Consultation-PE Only **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 31 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:** 412,038

2021 Work RVU: 0.00
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77338 **Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan**

Global: XXX **Issue:** IMRT - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 165,179

2021 Work RVU: 4.29
2021 NF PE RVU: 9.27
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77371 **Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based**

Global: XXX **Issue:** Radiation Treatment Delivery, Stereotactic Radiosurgery **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 30 **Specialty Developing Recommendation:** ASTRO **First Identified:** NA **2019 est Medicare Utilization:** 100

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77372 **Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:** 818

2021 Work RVU: 0.00
2021 NF PE RVU: 30.62
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77373 **Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASTRO, ACRO **First Identified:** July 2012 **2019 est Medicare Utilization:** 33,144

2021 Work RVU: 0.00
2021 NF PE RVU: 33.38
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77385 **Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77386 **Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77387 **Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.58 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77401 **Radiation treatment delivery, superficial and/or ortho voltage, per day**

Global: XXX **Issue:** Radiation Treatement Delivery (PE Only) **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 31 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 221,049

2021 Work RVU: 0.00
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** May 2019 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77402 **Radiation treatment delivery, >=1 MeV; simple**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 and Feburary 2014 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77403 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77404 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77406 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77407 **Radiation treatment delivery, >=1 MeV; intermediate**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77408 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77409 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77411 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77412 **Radiation treatment delivery, >=1 MeV; complex**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77413 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77414 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77416 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77418 **Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** CMS Fastest Growing / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009 and Q&A - Mar 2010

77421 **Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77422 **High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking**

Global: **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 35 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77423 **High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)**

Global: XXX **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 35 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77427 **Radiation treatment management, 5 treatments**

Global: XXX **Issue:** Radiation Treatment Management **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,043,579

2021 Work RVU: 3.37
2021 NF PE RVU: 1.88
2021 Fac PE RVU: 1.88

RUC Recommendation: 3.45. Remove from high E/M screen. **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77435 **Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 38,142

2021 Work RVU: 11.87
2021 NF PE RVU: 5.81
2021 Fac PE RVU: 5.81

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77470 **Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)**

Global: XXX **Issue:** Special Radiation Treatment **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 41 **Specialty Developing Recommendation:** ASTRO **First Identified:** July 2015 **2019 est Medicare Utilization:** 91,885

2021 Work RVU: 2.03
2021 NF PE RVU: 1.73
2021 Fac PE RVU: NA

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77520 **Proton treatment delivery; simple, without compensation**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2018 **2019 est Medicare Utilization:** 256

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77522 **Proton treatment delivery; simple, with compensation**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** January 2018 **2019 est Medicare Utilization:** 15,881

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77523 **Proton treatment delivery; intermediate**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** High Volume Growth4 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2016 **2019 est Medicare Utilization:** 47,302

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77525 **Proton treatment delivery; complex**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2018 **2019 est Medicare Utilization:** 20,144

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77600 **Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)**

Global: XXX **Issue:** Hyperthermia - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,464

2021 Work RVU: 1.31
2021 NF PE RVU: 12.92
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77767 **Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 5,362

2021 Work RVU: 1.05
2021 NF PE RVU: 6.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77768 **Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 7,665

2021 Work RVU: 1.40
2021 NF PE RVU: 9.17
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77770 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 17,117

2021 Work RVU: 1.95
2021 NF PE RVU: 8.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.95 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77771 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 17,697

2021 Work RVU: 3.80
2021 NF PE RVU: 13.63
2021 Fac PE RVU: NA

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77772 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,164

2021 Work RVU: 5.40
2021 NF PE RVU: 20.66
2021 Fac PE RVU: NA

RUC Recommendation: 5.40 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77776 **Interstitial radiation source application; simple**

Global: **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77777 **Interstitial radiation source application; intermediate**

Global: **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: 000 **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:** 4,806

2021 Work RVU: 8.78
2021 NF PE RVU: 16.56
2021 Fac PE RVU: NA

RUC Recommendation: 8.78 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77781 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77782 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77784 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77785 **Remote afterloading high dose rate radionuclide brachytherapy; 1 channel**

Global: **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77786 **Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels** **Global:** **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77787 **Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels** **Global:** **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77790 **Supervision, handling, loading of radiation source** **Global:** XXX **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASTRO, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 145

2021 Work RVU: 0.00
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** February 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78000 **Thyroid uptake; single determination** **Global:** **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78001 **Thyroid uptake; multiple determinations** **Global:** **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78003 **Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)** **Global:** **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78006 **Thyroid imaging, with uptake; single determination** **Global:** **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78007 **Thyroid imaging, with uptake; multiple determinations**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78010 **Thyroid imaging; only**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78011 **Thyroid imaging; with vascular flow**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78012 **Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 1,653

2021 Work RVU: 0.19
2021 NF PE RVU: 2.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78013 **Thyroid imaging (including vascular flow, when performed);**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 0.37
2021 NF PE RVU: 5.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78014 **Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 18,954

2021 Work RVU: 0.50
2021 NF PE RVU: 6.47
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78070 **Parathyroid planar imaging (including subtraction, when performed);**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 13,220

2021 Work RVU: 0.80
2021 NF PE RVU: 7.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

Status Report: CMS Requests and Relativity Assessment Issues

78071 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,974

2021 Work RVU: 1.20
2021 NF PE RVU: 9.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78072 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 12,267

2021 Work RVU: 1.60
2021 NF PE RVU: 11.34
2021 Fac PE RVU: NA

RUC Recommendation: 1.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78223 **Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function**

Global: **Issue:** Hepatobiliary Ductal System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78226 **Hepatobiliary system imaging, including gallbladder when present;**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2019 est Medicare Utilization:** 61,197

2021 Work RVU: 0.74
2021 NF PE RVU: 8.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78227 **Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2019 est Medicare Utilization:** 64,389

2021 Work RVU: 0.90
2021 NF PE RVU: 11.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78265 **Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit**

Global: XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,303

2021 Work RVU: 0.98
2021 NF PE RVU: 10.46
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2015

78266 **Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days**

Global: XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2019 est Medicare Utilization:** 313

2021 Work RVU: 1.08
2021 NF PE RVU: 11.62
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2015

Status Report: CMS Requests and Relativity Assessment Issues

78278 **Acute gastrointestinal blood loss imaging**

Global: XXX **Issue:** Acute GI Blood Loss Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 34 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 26,257

2021 Work RVU: 0.99
2021 NF PE RVU: 9.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.99 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78300 **Bone and/or joint imaging; limited area**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 6,808

2021 Work RVU: 0.62
2021 NF PE RVU: 6.06
2021 Fac PE RVU: NA

RUC Recommendation: 0.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78305 **Bone and/or joint imaging; multiple areas**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,645

2021 Work RVU: 0.83
2021 NF PE RVU: 7.27
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78306 **Bone and/or joint imaging; whole body**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 262,283

2021 Work RVU: 0.86
2021 NF PE RVU: 7.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78429 **Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.76 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78430 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.67 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78431 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78432 **Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.07 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78433 **Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.26 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78434 **Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.63 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78451 **Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 35,912

2021 Work RVU: 1.38
2021 NF PE RVU: 8.53
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78452 **Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 1,787,846

2021 Work RVU: 1.62
2021 NF PE RVU: 12.21
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78453 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 1,518

2021 Work RVU: 1.00
2021 NF PE RVU: 7.72
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78454 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 10,009

2021 Work RVU: 1.34
2021 NF PE RVU: 11.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.34 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78459 **Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:** 3,214

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.61 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78460 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78461 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78464 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78465 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78472 **Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing**

Global: XXX **Issue:** Cardiac Blood Pool Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 35 **Specialty Developing Recommendation:** ACC, ACR, SNM, ACNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 18,051

2021 Work RVU: 0.98
2021 NF PE RVU: 5.64
2021 Fac PE RVU: NA

RUC Recommendation: 0.98 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78478 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78480 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78491 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:** 1,809

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.56 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78492 **Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** October 2016 **2019 est Medicare Utilization:** 179,360

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78579 **Pulmonary ventilation imaging (eg, aerosol or gas)**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 360

2021 Work RVU: 0.49
2021 NF PE RVU: 4.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.49 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78580 **Pulmonary perfusion imaging (eg, particulate)**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** SNM, ACR

First Identified: February 2010 **2019 est Medicare Utilization:** 10,224

2021 Work RVU: 0.74
2021 NF PE RVU: 6.14
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78582 **Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM

First Identified: February 2010 **2019 est Medicare Utilization:** 165,031

2021 Work RVU: 1.07
2021 NF PE RVU: 8.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.07 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78584 **Pulmonary perfusion imaging, particulate, with ventilation; single breath**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR

First Identified: February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78585 **Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR

First Identified: October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78586 **Pulmonary ventilation imaging, aerosol; single projection**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78587 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78588 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78591 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78593 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78594 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78596 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78597 **Quantitative differential pulmonary perfusion, including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,640

2021 Work RVU: 0.75
2021 NF PE RVU: 5.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78598 **Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,383

2021 Work RVU: 0.85
2021 NF PE RVU: 8.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78803 **Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis), single day imaging**

Global: XXX **Issue:** RAW **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 14 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** January 2016 **2019 est Medicare Utilization:** 11,736

2021 Work RVU: 1.09
2021 NF PE RVU: 10.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78815 **Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2010 **2019 est Medicare Utilization:** 604,627

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Reaffirmed RUC recommendation **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

79101 **Radiopharmaceutical therapy, by intravenous administration**

Global: XXX **Issue:** Radiopharmaceutical Therapy **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 12,142

2021 Work RVU: 1.96
2021 NF PE RVU: 2.28
2021 Fac PE RVU: NA

RUC Recommendation: Article published Feb 2012 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2012

80500 **Clinical pathology consultation; limited, without review of patient's history and medical records**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2019 **2019 est Medicare Utilization:** 21,998

2021 Work RVU: 0.37
2021 NF PE RVU: 0.25
2021 Fac PE RVU: 0.16

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

80502 **Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU: 1.33
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.60

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX0

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.50 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

80XX1

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.91 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX2

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 1.80 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

80XX3

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.80 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

85060 **Blood smear, peripheral, interpretation by physician with written report**

Global: XXX **Issue:** Blood Smear Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 30 **Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2019 est Medicare Utilization:** 185,409

2021 Work RVU: 0.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.22

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

85097 **Bone marrow, smear interpretation**

Global: XXX **Issue:** Bone Marrow Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 31 **Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2019 est Medicare Utilization:** 140,727

2021 Work RVU: 0.94
2021 NF PE RVU: 1.01
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

85390 **Fibrinolysins or coagulopathy screen, interpretation and report**

Global: XXX **Issue:** Fibrinolysins Screen **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 34,588

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

88104 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 65,152

2021 Work RVU: 0.56
2021 NF PE RVU: 1.35
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88106 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,360

2021 Work RVU: 0.37
2021 NF PE RVU: 1.53
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88107 **Deleted from CPT**

Global: **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 17 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88108 **Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)**

Global: XXX **Issue:** Cytopathology Concentration Technique-PE Only **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** ACR, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 229,625

2021 Work RVU: 0.44
2021 NF PE RVU: 1.37
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88112 **Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal**

Global: XXX **Issue:** Cytopathology Concentration Technique-PE Only **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** ACR, CAP **First Identified:** September 2011 **2019 est Medicare Utilization:** 886,295

2021 Work RVU: 0.56
2021 NF PE RVU: 1.36
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88120 **Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual**

Global: XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** November 2012 **2019 est Medicare Utilization:** 49,876

2021 Work RVU: 1.20
2021 NF PE RVU: 16.90
2021 Fac PE RVU: NA

RUC Recommendation: Utilization shift is appropriate. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88121 **Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology**

Global: XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** November 2012 **2019 est Medicare Utilization:** 28,769

2021 Work RVU: 1.00
2021 NF PE RVU: 12.06
2021 Fac PE RVU: NA

RUC Recommendation: Utilization shift is appropriate. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88141 **Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP

First Identified: October 2017

2019 est Medicare Utilization: 55,857

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88160 **Cytopathology, smears, any other source; screening and interpretation**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 8,020

2021 Work RVU: 0.50
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

88161 **Cytopathology, smears, any other source; preparation, screening and interpretation**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 4,156

2021 Work RVU: 0.50
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

88162 **Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 1,306

2021 Work RVU: 0.76
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88184 **Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker**

Global: XXX **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 104,681

2021 Work RVU: 0.00
2021 NF PE RVU: 1.98
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued.

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88185 **Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)**

Global: ZZZ **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 1,918,080

2021 Work RVU: 0.00
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued.

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88187 **Flow cytometry, interpretation; 2 to 8 markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 42,225

2021 Work RVU: 0.74
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.74

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

88188 **Flow cytometry, interpretation; 9 to 15 markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 38,197

2021 Work RVU: 1.20
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.55

RUC Recommendation: 1.40

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

88189 **Flow cytometry, interpretation; 16 or more markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 222,162

2021 Work RVU: 1.70
2021 NF PE RVU: 0.65
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

88300 **Level I - Surgical pathology, gross examination only**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / Low Value-Billed in Multiple Units / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 207,562

2021 Work RVU: 0.08
2021 NF PE RVU: 0.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.08 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88302 **Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 75,443

2021 Work RVU: 0.13
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.13 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88304 **Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2019 est Medicare Utilization:** 967,907

2021 Work RVU: 0.22
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88305 **Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2019 est Medicare Utilization:** 17,561,979

2021 Work RVU: 0.75
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88307 **Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 983,152

2021 Work RVU: 1.59
2021 NF PE RVU: 6.65
2021 Fac PE RVU: NA

RUC Recommendation: 1.59 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88309 **Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection**

Global: XXX **Issue:** Pathology Services **Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 150,124

2021 Work RVU: 2.80
2021 NF PE RVU: 9.77
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88312 **Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,383,233

2021 Work RVU: 0.54
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88313 **Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,362,216

2021 Work RVU: 0.24
2021 NF PE RVU: 2.08
2021 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88314 **Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2019 est Medicare Utilization:** 21,474

2021 Work RVU: 0.45
2021 NF PE RVU: 2.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88318 **Deleted from CPT**

Global: **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 22 **Specialty Developing Recommendation:** CAP, AAD **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88319 **Special stain including interpretation and report; Group III, for enzyme constituents**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** **2019 est Medicare Utilization:** 17,807

2021 Work RVU: 0.53
2021 NF PE RVU: 3.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** June 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88321 **Consultation and report on referred slides prepared elsewhere**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 182,148

2021 Work RVU: 1.63
2021 NF PE RVU: 1.12
2021 Fac PE RVU: 0.71

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88323 **Consultation and report on referred material requiring preparation of slides**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 35,000

2021 Work RVU: 1.83
2021 NF PE RVU: 1.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.83 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88325 **Consultation, comprehensive, with review of records and specimens, with report on referred material**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 11,656

2021 Work RVU: 2.85
2021 NF PE RVU: 1.79
2021 Fac PE RVU: 1.06

RUC Recommendation: 2.85 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

88329 **Pathology consultation during surgery;**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 27,870

2021 Work RVU: 0.67
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88331 **Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 448,638

2021 Work RVU: 1.19
2021 NF PE RVU: 1.78
2021 Fac PE RVU: NA

RUC Recommendation: 1.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88332 **Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 163,257

2021 Work RVU: 0.59
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88333 **Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 39 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 69,359

2021 Work RVU: 1.20
2021 NF PE RVU: 1.53
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88334 **Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 39 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 31,996

2021 Work RVU: 0.73
2021 NF PE RVU: 0.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88341 **Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:** 3,097,983

2021 Work RVU: 0.56
2021 NF PE RVU: 2.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** April 2011 **2019 est Medicare Utilization:** 2,040,539

2021 Work RVU: 0.70
2021 NF PE RVU: 2.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** May 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88343 **Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure)**

Global: **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88344 **Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:** 132,224

2021 Work RVU: 0.77
2021 NF PE RVU: 4.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88346 **Immunofluorescence, per specimen; initial single antibody stain procedure** **Global:** XXX **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,000

2021 Work RVU: 0.74
2021 NF PE RVU: 3.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88347 **Immunofluorescent study, each antibody; indirect method** **Global:** **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88348 **Electron microscopy, diagnostic** **Global:** XXX **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 14 **Specialty Developing Recommendation:** CAP **First Identified:** October 2012 **2019 est Medicare Utilization:** 17,170

2021 Work RVU: 1.51
2021 NF PE RVU: 10.80
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88349 **Electron microscopy; scanning**

Global: **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 14 **Specialty Developing Recommendation:** CAP **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Oct 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88350 **Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** October 2014 **2019 est Medicare Utilization:** 260,841

2021 Work RVU: 0.59
2021 NF PE RVU: 2.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88356 **Morphometric analysis; nerve**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 37 **Specialty Developing Recommendation:** ASCP, CAP **First Identified:** April 2013 **2019 est Medicare Utilization:** 15,440

2021 Work RVU: 2.80
2021 NF PE RVU: 4.11
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88360 **Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual**

Global: XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 506,136

2021 Work RVU: 0.85
2021 NF PE RVU: 2.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88361 **Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology**

Global: XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 169,281

2021 Work RVU: 0.95
2021 NF PE RVU: 2.59
2021 Fac PE RVU: NA

RUC Recommendation: 0.95 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88364 **In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2019 est Medicare Utilization:** 28,908

2021 Work RVU: 0.70
2021 NF PE RVU: 3.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88365 **In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** September 2011 **2019 est Medicare Utilization:** 48,038

2021 Work RVU: 0.88
2021 NF PE RVU: 4.41
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

88366 **In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** May 2013 **2019 est Medicare Utilization:** 2,322

2021 Work RVU: 1.24
2021 NF PE RVU: 7.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88367 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,914

2021 Work RVU: 0.73
2021 NF PE RVU: 2.57
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

Status Report: CMS Requests and Relativity Assessment Issues

88368 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,780

2021 Work RVU: 0.88
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

88373 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2019 est Medicare Utilization:** 6,229

2021 Work RVU: 0.58
2021 NF PE RVU: 1.51
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** **2019 est Medicare Utilization:** 113,039

2021 Work RVU: 0.93
2021 NF PE RVU: 9.15
2021 Fac PE RVU: NA

RUC Recommendation: 1.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88377 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** May 2013 **2019 est Medicare Utilization:** 152,595

2021 Work RVU: 1.40
2021 NF PE RVU: 10.73
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

90465 **Deleted from CPT**

Global: **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90467 **Deleted from CPT**

Global: **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90471 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** February 2008 **2019 est Medicare Utilization:** 282,357

2021 Work RVU: 0.17
2021 NF PE RVU: 0.31
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90472 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** February 2008 **2019 est Medicare Utilization:** 22,524

2021 Work RVU: 0.15
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90473 **Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:** 3

2021 Work RVU: 0.17
2021 NF PE RVU: 0.31
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90474 **Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:** 1

2021 Work RVU: 0.15
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 408,566

2021 Work RVU: 0.33
2021 NF PE RVU: 0.09
2021 Fac PE RVU: 0.04

RUC Recommendation: Refer to CPT Review in 3 years (Oct 2023). 0.33 **Referred to CPT** October 2020 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90791 **Psychiatric diagnostic evaluation**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 917,143

2021 Work RVU: 3.84
2021 NF PE RVU: 1.20
2021 Fac PE RVU: 0.50

RUC Recommendation: 3.00 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90792 **Psychiatric diagnostic evaluation with medical services**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 586,327

2021 Work RVU: 4.16
2021 NF PE RVU: 1.47
2021 Fac PE RVU: 0.75

RUC Recommendation: 3.25 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90801 **Psychiatric diagnostic interview examination**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90805 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90806 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

90808 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

90818 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

90832 **Psychotherapy, 30 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,306,870

2021 Work RVU: 1.70
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.22

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90833 **Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,401,042

2021 Work RVU: 1.50
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.27

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90834 **Psychotherapy, 45 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 4,939,452

2021 Work RVU: 2.24
2021 NF PE RVU: 0.63
2021 Fac PE RVU: 0.28

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90836 **Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 510,888

2021 Work RVU: 1.90
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.34

RUC Recommendation: 1.90 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90837 **Psychotherapy, 60 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,027,217

2021 Work RVU: 3.31
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.42

RUC Recommendation: 3.00 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90838 **Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 100,884

2021 Work RVU: 2.50
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.46

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90839 **Psychotherapy for crisis; first 60 minutes** **Global:** XXX **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 35 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 23,040

2021 Work RVU: 3.13
2021 NF PE RVU: 0.90
2021 Fac PE RVU: 0.41

RUC Recommendation: 3.13 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90840 **Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)** **Global:** ZZZ **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 35 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,284

2021 Work RVU: 1.50
2021 NF PE RVU: 0.42
2021 Fac PE RVU: 0.19

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90845 **Psychoanalysis** **Global:** XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2011 **Tab:** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 5,591

2021 Work RVU: 2.10
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.31

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90846 **Family psychotherapy (without the patient present), 50 minutes** **Global:** XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 21,975

2021 Work RVU: 2.40
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.33

RUC Recommendation: 2.40 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90847 **Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 178,166

2021 Work RVU: 2.50
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.33

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90853 **Group psychotherapy (other than of a multiple-family group)**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 906,163

2021 Work RVU: 0.59
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.59 **Referred to CPT** February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

90862 **Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90863 **Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)**

Global: XXX **Issue:** Pharmacologic Management with Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 40 **Specialty Developing Recommendation:** APA (HCPAC) **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU: 0.48
2021 NF PE RVU: 0.23
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.48 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90868 **Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session**

Global: 000 **Issue:** **Screen:** Contractor Priced High Volume **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2019 est Medicare Utilization:** 238,754

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review in 2 years (Oct 2020) **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

90870 **Electroconvulsive therapy (includes necessary monitoring)**

Global: 000 **Issue:** Electroconvulsive Therapy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 41 **Specialty Developing Recommendation:** APA **First Identified:** October 2009 **2019 est Medicare Utilization:** 126,401

2021 Work RVU: 2.50
2021 NF PE RVU: 2.49
2021 Fac PE RVU: 0.51

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90911 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry**

Global: **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** April 2017 **2019 est Medicare Utilization:** 28,865

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90912 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient**

Global: 000 **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.90
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.90 **Referred to CPT** February 2019-EC **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90913 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 0.40
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.50 **Referred to CPT** February 2019-EC **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90935 **Hemodialysis procedure with single evaluation by a physician or other qualified health care professional**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,098,691

2021 Work RVU: 1.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90937 **Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 51,752

2021 Work RVU: 2.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

90945 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 165,382

2021 Work RVU: 1.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.56 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90947 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 11,769

2021 Work RVU: 2.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.91

RUC Recommendation: 2.52 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90951 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 17

2021 Work RVU: 23.92
2021 NF PE RVU: 8.88
2021 Fac PE RVU: 8.88

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90952 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 4

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90953 **End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90954 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 571

2021 Work RVU: 15.98
2021 NF PE RVU: 5.66
2021 Fac PE RVU: 5.66

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90955 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 57

2021 Work RVU: 10.32
2021 NF PE RVU: 4.37
2021 Fac PE RVU: 4.37

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90956 **End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 124

2021 Work RVU: 6.64
2021 NF PE RVU: 3.10
2021 Fac PE RVU: 3.10

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90957 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,539

2021 Work RVU: 15.46
2021 NF PE RVU: 6.19
2021 Fac PE RVU: 6.19

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90958 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 393

2021 Work RVU: 9.87
2021 NF PE RVU: 4.23
2021 Fac PE RVU: 4.23

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90959 **End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 292

2021 Work RVU: 6.19
2021 NF PE RVU: 2.93
2021 Fac PE RVU: 2.93

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90960 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 2,218,361

2021 Work RVU: 6.77
2021 NF PE RVU: 3.20
2021 Fac PE RVU: 3.20

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90961 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 719,245

2021 Work RVU: 5.52
2021 NF PE RVU: 2.75
2021 Fac PE RVU: 2.75

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90962 **End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 213,048

2021 Work RVU: 3.57
2021 NF PE RVU: 2.11
2021 Fac PE RVU: 2.11

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90963 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 229

2021 Work RVU: 12.09
2021 NF PE RVU: 4.93
2021 Fac PE RVU: 4.93

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90964 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 934

2021 Work RVU: 10.25
2021 NF PE RVU: 4.37
2021 Fac PE RVU: 4.37

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90965 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,343

2021 Work RVU: 9.80
2021 NF PE RVU: 4.26
2021 Fac PE RVU: 4.26

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90966 **End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 365,733

2021 Work RVU: 5.52
2021 NF PE RVU: 2.74
2021 Fac PE RVU: 2.74

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

91038 **Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)**

Global: 000 **Issue:** Gastroenterological Tests **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 23 **Specialty Developing Recommendation:** AGA, ASGE **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,829

2021 Work RVU: 1.10
2021 NF PE RVU: 12.08
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

91110 **Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report**

Global: XXX **Issue:** Gastrointestinal Tract Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 44 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** July 2015 **2019 est Medicare Utilization:** 53,131

2021 Work RVU: 2.49
2021 NF PE RVU: 22.79
2021 Fac PE RVU: NA

RUC Recommendation: 2.49 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

91111 **Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report**

Global: XXX **Issue:** Gastrointestinal Tract Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 44 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** July 2015 **2019 est Medicare Utilization:** 146

2021 Work RVU: 1.00
2021 NF PE RVU: 26.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

91132 **Electrogastrography, diagnostic, transcutaneous;**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2019 est Medicare Utilization:** 114

2021 Work RVU: 0.52
2021 NF PE RVU: 11.72
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91133 **Electrogastrography, diagnostic, transcutaneous; with provocative testing**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2019 est Medicare Utilization:** 14

2021 Work RVU: 0.66
2021 NF PE RVU: 12.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92065 **Orthoptic and/or pleoptic training, with continuing medical direction and evaluation**

Global: XXX **Issue:** Orthoptic Training **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 09 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 32,858

2021 Work RVU: 0.37
2021 NF PE RVU: 1.17
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 May 2020-Tab 37 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

92081 **Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2019 est Medicare Utilization:** 92,708

2021 Work RVU: 0.30
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92082 **Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2019 est Medicare Utilization:** 122,984

2021 Work RVU: 0.40
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92083 **Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)**

Global: XXX **Issue:** Visual Field Examination **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 46 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,969,637

2021 Work RVU: 0.50
2021 NF PE RVU: 1.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92100 **Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)**

Global: XXX **Issue:** Serial Tonometry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 31,551

2021 Work RVU: 0.61
2021 NF PE RVU: 1.85
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92133 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,814,680

2021 Work RVU: 0.40
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92134 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** October 2008 **2019 est Medicare Utilization:** 7,509,080

2021 Work RVU: 0.45
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92135 **Deleted from CPT**

Global: **Issue:** Ophthalmic Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 31 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92136 **Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation**

Global: XXX **Issue:** Ophthalmic Biometry **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,688,098

2021 Work RVU: 0.54
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92140 **Provocative tests for glaucoma, with interpretation and report, without tonography**

Global: **Issue:** Glaucoma Provacative Tests **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 41 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92201 **Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.40
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.24

RUC Recommendation: 0.40 **Referred to CPT** February 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92202 **Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.26
2021 NF PE RVU: 0.19
2021 Fac PE RVU: 0.15

RUC Recommendation: 0.26 **Referred to CPT** February 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92225 **Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial**

Global: **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** April 2017 **2019 est Medicare Utilization:** 947,451

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92226 **Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent**

Global: **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:** 2,551,942

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92235 **Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2011 **2019 est Medicare Utilization:** 428,183

2021 Work RVU: 0.75
2021 NF PE RVU: 2.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92240 **Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** January 2015 **2019 est Medicare Utilization:** 10,668

2021 Work RVU: 0.80
2021 NF PE RVU: 5.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92242 **Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2015 **2019 est Medicare Utilization:** 37,989

2021 Work RVU: 0.95
2021 NF PE RVU: 6.37
2021 Fac PE RVU: NA

RUC Recommendation: 0.95 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92250 **Fundus photography with interpretation and report**

Global: XXX **Issue:** Fundus Photography **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 45 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** October 2010 **2019 est Medicare Utilization:** 3,490,129

2021 Work RVU: 0.40
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92270 **Electro-oculography with interpretation and report**

Global: XXX **Issue:** Electro-oculography **Screen:** High Volume Growth1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,435

2021 Work RVU: 0.81
2021 NF PE RVU: 2.17
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published.

Referred to CPT February 2014 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2008 and Q&A Jun 2009

92273 **Electroretinography (ERG), with interpretation and report; full field (ie, ffERG, flash ERG, Ganzfeld ERG)**

Global: XXX **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 / Work Neutrality 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 68,699

2021 Work RVU: 0.69
2021 NF PE RVU: 3.11
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan. 0.80

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92274 **Electroretinography (ERG), with interpretation and report; multifocal (mfERG)**

Global: XXX **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 / Work Neutrality 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 6,340

2021 Work RVU: 0.61
2021 NF PE RVU: 1.97
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan. 0.72

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

92275 **Electroretinography with interpretation and report**

Global: **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 17 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92284 **Dark adaptation examination with interpretation and report**

Global: XXX **Issue:** **Screen:** Harvard Valued - Utilization over 30,000-Part5 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.24
2021 NF PE RVU: 1.45
2021 Fac PE RVU: NA

RUC Recommendation: Survey with family **Referred to CPT** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

92285 **External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)**

Global: XXX **Issue:** Ocular Photography **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 32 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2019 est Medicare Utilization:** 406,118

2021 Work RVU: 0.05
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.05 and new PE inputs **Referred to CPT** February 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92286 **Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 28 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 115,474

2021 Work RVU: 0.40
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92287 **Anterior segment imaging with interpretation and report; with fluorescein angiography**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** **2019 est Medicare Utilization:** 7,182

2021 Work RVU: 0.81
2021 NF PE RVU: 4.21
2021 Fac PE RVU: NA

RUC Recommendation: Survey **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2013

92504 **Binocular microscopy (separate diagnostic procedure)**

Global: XXX **Issue:** Binocular Microscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 43 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 239,518

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92506 **Evaluation of speech, language, voice, communication, and/or auditory processing**

Global: **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA

First Identified: **2019 est Medicare Utilization:**

2021 Work RVU: **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92507 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth 3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ASHA

First Identified: October 2015 **2019 est Medicare Utilization:** 350,653

2021 Work RVU: 1.30 **2021 NF PE RVU:** 0.89 **2021 Fac PE RVU:** NA

RUC Recommendation: 1.30 work RVU and clinical staff time removed. Remove from High Volume screen. **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92508 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA

First Identified: **2019 est Medicare Utilization:** 4,438

2021 Work RVU: 0.33 **2021 NF PE RVU:** 0.35 **2021 Fac PE RVU:** NA

RUC Recommendation: 0.43 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92521 **Evaluation of speech fluency (eg, stuttering, cluttering)**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 197

2021 Work RVU: 2.24
2021 NF PE RVU: 1.59
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92522 **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 3,374

2021 Work RVU: 1.92
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92523 **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 19,962

2021 Work RVU: 3.84
2021 NF PE RVU: 2.75
2021 Fac PE RVU: NA

RUC Recommendation: 3.36 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92524 **Behavioral and qualitative analysis of voice and resonance**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 18,441

2021 Work RVU: 1.92
2021 NF PE RVU: 1.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92526 **Treatment of swallowing dysfunction and/or oral function for feeding**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 133,424

2021 Work RVU: 1.34
2021 NF PE RVU: 1.09
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92537 **Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)**

Global: XXX **Issue:** Vestibular Caloric Irrigation **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** October 2014 **2019 est Medicare Utilization:** 68,931

2021 Work RVU: 0.60
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92538 **Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)**

Global: XXX **Issue:** Vestibular Caloric Irrigation **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** October 2014 **2019 est Medicare Utilization:** 6,794

2021 Work RVU: 0.30
2021 NF PE RVU: 0.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92540 **Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 89,363

2021 Work RVU: 1.50
2021 NF PE RVU: 1.66
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92541 **Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 13,573

2021 Work RVU: 0.40
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92542 **Positional nystagmus test, minimum of 4 positions, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 19,332

2021 Work RVU: 0.48
2021 NF PE RVU: 0.36
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** February 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: **Issue:** Vestibular Caloric Irrigation **Screen:** Codes Reported Together 95% or More / Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92544 **Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,943

2021 Work RVU: 0.27
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92545 **Oscillating tracking test, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,622

2021 Work RVU: 0.25
2021 NF PE RVU: 0.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** February 2009 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92546 **Sinusoidal vertical axis rotational testing**

Global: XXX **Issue:** EOG VNG **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** **First Identified:** February 2014 **2019 est Medicare Utilization:** 43,026

2021 Work RVU: 0.29
2021 NF PE RVU: 3.16
2021 Fac PE RVU: NA

RUC Recommendation: Editorial change only **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92547 **Use of vertical electrodes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EOG VNG **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** **First Identified:** February 2014 **2019 est Medicare Utilization:** 26,526

2021 Work RVU: 0.00
2021 NF PE RVU: 0.29
2021 Fac PE RVU: NA

RUC Recommendation: Editorial change only **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92548 **Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;**

Global: XXX **Issue:** Computerized Dynamic Posturography **Screen:** CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 16 **Specialty Developing Recommendation:** AAA, AAN, ASHA **First Identified:** February 2014 **2019 est Medicare Utilization:** 51,157

2021 Work RVU: 0.67
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.76 **Referred to CPT** September 2018 / February 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92549 **Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)**

Global: XXX **Issue:** Computerized Dynamic Posturography **Screen:** CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 16 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.87
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.96 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92550 **Tympanometry and reflex threshold measurements**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 231,898

2021 Work RVU: 0.35
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92557 **Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,255,685

2021 Work RVU: 0.60
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.60 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92558 **Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** February 2011 **2019 est Medicare Utilization:**

2021 Work RVU: 0.17
2021 NF PE RVU: 0.10
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.17 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92567 **Tympanometry (impedance testing)**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 922,916

2021 Work RVU: 0.20
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.10

RUC Recommendation: 0.20 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92568 **Acoustic reflex testing, threshold** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,046

2021 Work RVU: 0.29
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.29 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92569 **Deleted from CPT** **Global:** **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92570 **Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 38,849

2021 Work RVU: 0.55
2021 NF PE RVU: 0.38
2021 Fac PE RVU: 0.28

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92584 **Electrocochleography** **Global:** XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:** 11,016

2021 Work RVU: 1.00
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92585 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** October 2017 **2019 est Medicare Utilization:** 34,565

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92586 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:** 1,425

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92587 **Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** October 2008 **2019 est Medicare Utilization:** 58,068

2021 Work RVU: 0.35
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92588 **Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 85,077

2021 Work RVU: 0.55
2021 NF PE RVU: 0.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92597 **Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 30 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2019 est Medicare Utilization:** 2,839

2021 Work RVU: 1.26
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92605 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 1.75
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.75 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92606 **Therapeutic service(s) for the use of non-speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 1.40
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.54

RUC Recommendation: 1.40 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92607 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 544

2021 Work RVU: 1.85
2021 NF PE RVU: 1.75
2021 Fac PE RVU: NA

RUC Recommendation: 1.85 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92608 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 220

2021 Work RVU: 0.70
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92609 **Therapeutic services for the use of speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 14,910

2021 Work RVU: 1.50
2021 NF PE RVU: 1.51
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92610 **Evaluation of oral and pharyngeal swallowing function**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 22,897

2021 Work RVU: 1.30
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.68

RUC Recommendation: Maintain **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92611 **Motion fluoroscopic evaluation of swallowing function by cine or video recording**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 39 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2019 est Medicare Utilization:** 9,673

2021 Work RVU: 1.34
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 1.34 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92618 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 0.65
2021 NF PE RVU: 0.26
2021 Fac PE RVU: 0.25

RUC Recommendation: 0.65 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92620 **Evaluation of central auditory function, with report; initial 60 minutes**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 818

2021 Work RVU: 1.50
2021 NF PE RVU: 1.15
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92621 **Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 43

2021 Work RVU: 0.35
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92625 **Assessment of tinnitus (includes pitch, loudness matching, and masking)** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 9,371

2021 Work RVU: 1.15
2021 NF PE RVU: 0.83
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92626 **Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 30 **Specialty Developing Recommendation:** AAA, ASHA **First Identified:** NA **2019 est Medicare Utilization:** 29,623

2021 Work RVU: 1.40
2021 NF PE RVU: 1.17
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.40 **Referred to CPT** May 2018 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

92627 **Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 30 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 7,594

2021 Work RVU: 0.33
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.33 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92640 **Diagnostic analysis with programming of auditory brainstem implant, per hour** **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 11

2021 Work RVU: 1.76
2021 NF PE RVU: 1.50
2021 Fac PE RVU: 0.95

RUC Recommendation: 1.76 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92650 **Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis** **Global:** XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.25
2021 NF PE RVU: 0.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** February 2019 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92651 **Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report** **Global:** XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.00
2021 NF PE RVU: 1.57
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92652 **Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report** **Global:** XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92653 **Auditory evoked potentials; neurodiagnostic, with interpretation and report** **Global:** XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ACNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.05
2021 NF PE RVU: 1.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92920 **Percutaneous transluminal coronary angioplasty; single major coronary artery or branch** **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 24,084

2021 Work RVU: 9.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.43

RUC Recommendation: 9.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92921 **Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 4.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92924 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch** **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,282

2021 Work RVU: 11.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.09

RUC Recommendation: 11.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92925 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92928 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 254,826

2021 Work RVU: 10.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.81

RUC Recommendation: 10.49 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92929 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 4.44 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92933 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 19,416

2021 Work RVU: 12.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.27

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92934 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5.50 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92937 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 18,930

2021 Work RVU: 10.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.80

RUC Recommendation: 10.49 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92938 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 6.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92941 **Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 41,108

2021 Work RVU: 12.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92943 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 9,129

2021 Work RVU: 12.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92944 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 6.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92960 **Cardioversion, elective, electrical conversion of arrhythmia; external**

Global: 000 **Issue:** Cardioversion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 201,622

2021 Work RVU: 2.00
2021 NF PE RVU: 2.49
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92973 **Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,130

2021 Work RVU: 3.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.14

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92980 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92981 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92982 **Percutaneous transluminal coronary balloon angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92984 **Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92986 **Percutaneous balloon valvuloplasty; aortic valve**

Global: 090 **Issue:** Valvuloplasty **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 2,857

2021 Work RVU: 22.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.90

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

92992 **Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 76

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92993 **Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 1

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92995 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92996 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93000 **Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC **First Identified:** September 2011 **2019 est Medicare Utilization:** 11,883,535

2021 Work RVU: 0.17
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93005 **Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 460,887

2021 Work RVU: 0.00
2021 NF PE RVU: 0.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93010 **Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 18,866,949

2021 Work RVU: 0.17
2021 NF PE RVU: 0.06
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93012 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93014 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93015 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 999,644

2021 Work RVU: 0.75
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 0.75. CPT Assistant published. **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93016 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,047,732

2021 Work RVU: 0.45
2021 NF PE RVU: 0.16
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93017 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress **Screen:** High Volume Growth1 / CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 96,453

2021 Work RVU: 0.00
2021 NF PE RVU: 0.99
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93018 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only**

Global: XXX **Issue:** Cardiovascular Stress Tests and Echocardiography **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,241,516

2021 Work RVU: 0.30
2021 NF PE RVU: 0.11
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.30 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93025 **Microvolt T-wave alternans for assessment of ventricular arrhythmias**

Global: XXX **Issue:** Microvolt T-Wave Assessment **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 18 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:** 213

2021 Work RVU: 0.75
2021 NF PE RVU: 3.15
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93040 **Rhythm ECG, 1-3 leads; with interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC

First Identified: February 2009 **2019 est Medicare Utilization:** 108,714

2021 Work RVU: 0.15
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.15

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

93041 **Rhythm ECG, 1-3 leads; tracing only without interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC

First Identified: February 2009 **2019 est Medicare Utilization:** 12,914

2021 Work RVU: 0.00
2021 NF PE RVU: 0.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 (PE only)

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

93042 **Rhythm ECG, 1-3 leads; interpretation and report only**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC, ACEP

First Identified: October 2008 **2019 est Medicare Utilization:** 362,235

2021 Work RVU: 0.15
2021 NF PE RVU: 0.04
2021 Fac PE RVU: 0.04

RUC Recommendation: 0.15

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

93224 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 284,557

2021 Work RVU: 0.39
2021 NF PE RVU: 1.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93225 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 110,328

2021 Work RVU: 0.00
2021 NF PE RVU: 0.57
2021 Fac PE RVU: NA

RUC Recommendation: N/A no physician work **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93226 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 154,751

2021 Work RVU: 0.00
2021 NF PE RVU: 1.18
2021 Fac PE RVU: NA

RUC Recommendation: N/A no physician work **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93227 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 344,162

2021 Work RVU: 0.39
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.52 **Referred to CPT** Feburary 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93228 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 20 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2009 **2019 est Medicare Utilization:** 186,123

2021 Work RVU: 0.52
2021 NF PE RVU: 0.19
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93229 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 20 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2009 **2019 est Medicare Utilization:** 271,792

2021 Work RVU: 0.00
2021 NF PE RVU: 20.46
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93230 **Deleted from CPT**

Global: **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93231 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93232 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93233 **Deleted from CPT**

Global: **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93235 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93236 **Deleted from CPT**

Global: **Issue:** Cardiovascular Stress Test **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93237 **Deleted from CPT**

Global: **Issue:** Wearable Cardiac Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93268 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 11,689

2021 Work RVU: 0.52
2021 NF PE RVU: 5.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93270 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 39,075

2021 Work RVU: 0.00
2021 NF PE RVU: 0.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** February 2010 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93271 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 54,627

2021 Work RVU: 0.00
2021 NF PE RVU: 4.79
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** February 2010 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93272 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 104,829

2021 Work RVU: 0.52
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93279 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 152,741

2021 Work RVU: 0.65
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.65 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93280 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 986,249

2021 Work RVU: 0.77
2021 NF PE RVU: 1.47
2021 Fac PE RVU: NA

RUC Recommendation: 0.77 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93281 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 73,701

2021 Work RVU: 0.85
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93282 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 115,690

2021 Work RVU: 0.85
2021 NF PE RVU: 1.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93283 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 214,401

2021 Work RVU: 1.15
2021 NF PE RVU: 1.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.15 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93284 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 246,603

2021 Work RVU: 1.25
2021 NF PE RVU: 1.77
2021 Fac PE RVU: NA

RUC Recommendation: 1.25 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93285 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 40,620

2021 Work RVU: 0.52
2021 NF PE RVU: 1.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93286 **Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 20,480

2021 Work RVU: 0.30
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93287 **Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 12,854

2021 Work RVU: 0.45
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93288 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 242,876

2021 Work RVU: 0.43
2021 NF PE RVU: 1.15
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93289 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 97,500

2021 Work RVU: 0.75
2021 NF PE RVU: 1.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93290 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 118,819

2021 Work RVU: 0.43
2021 NF PE RVU: 1.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93291 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 68,111

2021 Work RVU: 0.37
2021 NF PE RVU: 1.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** February 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93292 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,142

2021 Work RVU: 0.43
2021 NF PE RVU: 0.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93293 **Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 50,828

2021 Work RVU: 0.31
2021 NF PE RVU: 1.15
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93294 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,162,316

2021 Work RVU: 0.60
2021 NF PE RVU: 0.24
2021 Fac PE RVU: 0.24

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93295 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 618,312

2021 Work RVU: 0.74
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93296 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,298,857

2021 Work RVU: 0.00
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs and Refer to CPT **Referred to CPT** February 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93297 **Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 436,176

2021 Work RVU: 0.52
2021 NF PE RVU: 0.21
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93298 **Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 718,193

2021 Work RVU: 0.52
2021 NF PE RVU: 0.21
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93299 **Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results**

Global: **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 790,455

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93306 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography**

Global: XXX **Issue:** Complete Transthoracic Echocardiography (TTE) with Doppler **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 21 **Specialty Developing Recommendation:** ACC, ASE **First Identified:** July 2015 **2019 est Medicare Utilization:** 7,396,555

2021 Work RVU: 1.46
2021 NF PE RVU: 4.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93307 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography**

Global: XXX **Issue:** Transthoracic Echocardiography (TTE) **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 42 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:** 26,672

2021 Work RVU: 0.92
2021 NF PE RVU: 3.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.92 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93308 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study**

Global: XXX **Issue:** Transthoracic Echocardiography (TTE) **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 42 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 435,885

2021 Work RVU: 0.53
2021 NF PE RVU: 2.39
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93320 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 365,942

2021 Work RVU: 0.38
2021 NF PE RVU: 1.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.38 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93321 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC

First Identified: October 2013

2019 est Medicare Utilization: 239,405

2021 Work RVU: 0.15
2021 NF PE RVU: 0.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.15

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93325 **Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC

First Identified: February 2009

2019 est Medicare Utilization: 606,488

2021 Work RVU: 0.07
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.07

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93350 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;**

Global: XXX **Issue:** Stress Transthoracic Echocardiography (TTE) Complete **Screen:** Other - Identified by RUC / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 26 **Specialty Developing Recommendation:** ACC, ASE

First Identified: April 2008

2019 est Medicare Utilization: 95,788

2021 Work RVU: 1.46
2021 NF PE RVU: 4.11
2021 Fac PE RVU: NA

RUC Recommendation: 1.46; CPT Assistant article published

Referred to CPT October 2010

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

Status Report: CMS Requests and Relativity Assessment Issues

93351 **Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional**

Global: XXX **Issue:** Stress Transthoracic Echocardiography (TTE) Complete **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 26 **Specialty Developing Recommendation:** ACC, ASE **First Identified:** July 2015 **2019 est Medicare Utilization:** 241,940

2021 Work RVU: 1.75
2021 NF PE RVU: 5.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93451 **Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 44,232

2021 Work RVU: 2.47
2021 NF PE RVU: 23.82
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Modifier -51 exempt list. 3.02 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93452 **Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 3,594

2021 Work RVU: 4.50
2021 NF PE RVU: 22.80
2021 Fac PE RVU: NA

RUC Recommendation: 4.32 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93453 **Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 2,368

2021 Work RVU: 5.99
2021 NF PE RVU: 28.76
2021 Fac PE RVU: NA

RUC Recommendation: 5.98 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93454 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 127,375

2021 Work RVU: 4.54
2021 NF PE RVU: 22.77
2021 Fac PE RVU: NA

RUC Recommendation: 4.95 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93455 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 27,649

2021 Work RVU: 5.29
2021 NF PE RVU: 25.34
2021 Fac PE RVU: NA

RUC Recommendation: 6.15 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93456 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 19,829

2021 Work RVU: 5.90
2021 NF PE RVU: 28.29
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Modifier -51 Exempt List. 6.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93457 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 3,711

2021 Work RVU: 6.64
2021 NF PE RVU: 30.82
2021 Fac PE RVU: NA

RUC Recommendation: 7.66 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93458 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 507,961

2021 Work RVU: 5.60
2021 NF PE RVU: 25.90
2021 Fac PE RVU: NA

RUC Recommendation: 6.51 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93459 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 90,436

2021 Work RVU: 6.35
2021 NF PE RVU: 27.63
2021 Fac PE RVU: NA

RUC Recommendation: 7.34 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93460 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 89,701

2021 Work RVU: 7.10
2021 NF PE RVU: 30.59
2021 Fac PE RVU: NA

RUC Recommendation: 7.88 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93461 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 14,051

2021 Work RVU: 7.85
2021 NF PE RVU: 33.97
2021 Fac PE RVU: NA

RUC Recommendation: 9.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93462 **Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6,479

2021 Work RVU: 3.73
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 1.60

RUC Recommendation: 3.73 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93463 **Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6,287

2021 Work RVU: 2.00
2021 NF PE RVU: 0.70
2021 Fac PE RVU: 0.70

RUC Recommendation: 2.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93464 **Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 1,054

2021 Work RVU: 1.80
2021 NF PE RVU: 5.08
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93501 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93503 **Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 71,386

2021 Work RVU: 2.00

2021 NF PE RVU: NA

2021 Fac PE RVU: 0.38

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93508 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93510 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More/ CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93511 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93514 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93524 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93526 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93527 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93528 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93529 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93539 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93540 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93541 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93542 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93543 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93544 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93545 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93555 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93556 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93561 **Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)**

Global: ZZZ **Issue:** Cardiac Output Measurement **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 27 **Specialty Developing Recommendation:**

First Identified: October 2017 **2019 est Medicare Utilization:** 6

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93562 **Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output**

Global: ZZZ **Issue:** Cardiac Output Measurement **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 27 **Specialty Developing Recommendation:**

First Identified: October 2017 **2019 est Medicare Utilization:** 14

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 0.95 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93563 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 167

2021 Work RVU: 1.11
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.39

RUC Recommendation: 2.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93564 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6

2021 Work RVU: 1.13
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.39

RUC Recommendation: 2.10 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93565 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 80

2021 Work RVU: 0.86
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.30

RUC Recommendation: 1.90 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93566 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 388

2021 Work RVU: 0.86
2021 NF PE RVU: 3.14
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.96 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93567 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 28,640

2021 Work RVU: 0.97
2021 NF PE RVU: 2.33
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.97 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93568 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 1,334

2021 Work RVU: 0.88
2021 NF PE RVU: 2.81
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.98 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93571 **Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2016 **2019 est Medicare Utilization:** 69,945

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93572 **Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2017 **2019 est Medicare Utilization:** 12,600

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93613 **Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intracardiac 3D Mapping add-on **Screen:** CMS Fastest Growing / High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 24 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2019 est Medicare Utilization:** 80,773

2021 Work RVU: 5.23
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.27

RUC Recommendation: 5.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93620 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording**

Global: 000 **Issue:** Intracardiac Catheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC

First Identified: February 2010 **2019 est Medicare Utilization:** 8,849

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 11.57 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93621 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Electrophysiologic Evaluation **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: October 2019 **2019 est Medicare Utilization:** 29,892

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93623 **Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pacing Heart Stimulation **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2018 **2019 est Medicare Utilization:** 38,626

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Referral to CPT for parenthetical. 2.04 **Referred to CPT** May 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93641 **Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator**

Global: 000 **Issue:** Insertion/Removal of Pacemaker or Pacing Carioverter-Defibillator **Screen:** Codes Reported Together 75% or More-Part1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,210

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 2B.

Referred to CPT February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93651 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93652 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** CMS Fastest Growing/Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93653 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 31,821

2021 Work RVU: 14.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.40

RUC Recommendation: 18.49 (Interim) **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93654 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 7,750

2021 Work RVU: 19.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.55

RUC Recommendation: 19.75 (Interim) **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93655 **Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 /High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 31,147

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.27

RUC Recommendation: 6.50 (Interim) **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93656 **Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 53,327

2021 Work RVU: 19.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.63

RUC Recommendation: 20.00 (Interim) **Referred to CPT** October 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93657 **Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 21,959

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.26

RUC Recommendation: 6.50 (Interim) **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93662 **Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intracardiac Echocardiography **Screen:** High Volume Growth1 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS

First Identified: February 2008 **2019 est Medicare Utilization:** 63,470

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.53 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93668 **Peripheral arterial disease (PAD) rehabilitation, per session**

Global: XXX **Issue:** Peripheral Artery Disease (PAD) Rehabilitation (PE Only) **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 28 **Specialty Developing Recommendation:**

First Identified: July 2017 **2019 est Medicare Utilization:** 814

2021 Work RVU: 0.00
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93701 **Bioimpedance-derived physiologic cardiovascular analysis**

Global: XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: October 2010 **2019 est Medicare Utilization:** 14,268

2021 Work RVU: 0.00
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

93731 **Deleted from CPT**

Global: **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC

First Identified: October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93732 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93733 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93743 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93744 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93750 **Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report**

Global: XXX **Issue:** Ventricular Assist Device (VAD) Interrogation **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 24 **Specialty Developing Recommendation:** AATS, ACC, STS **First Identified:** October 2018 **2019 est Medicare Utilization:** 97,423

2021 Work RVU: 0.75
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93792 **Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,742

2021 Work RVU: 0.00
2021 NF PE RVU: 1.90
2021 Fac PE RVU: NA

RUC Recommendation: Reviewe in 2 years. 0.00 PE Only **Referred to CPT** September 2016 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

93793 **Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,555,390

2021 Work RVU: 0.18
2021 NF PE RVU: 0.14
2021 Fac PE RVU: NA

RUC Recommendation: Review in 2 years. 0.18 **Referred to CPT** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93875 **Deleted from CPT**

Global: **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** SS in process of developing draft of CPT Asst article (Aug 2011). Code was deleted

---

93880 **Duplex scan of extracranial arteries; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ACC, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,198,611

2021 Work RVU: 0.80
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Addressed in CPT Coding Changes

---

93882 **Duplex scan of extracranial arteries; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** January 2012 **2019 est Medicare Utilization:** 33,564

2021 Work RVU: 0.50
2021 NF PE RVU: 3.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93886 **Transcranial Doppler study of the intracranial arteries; complete study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 104,495

2021 Work RVU: 0.91
2021 NF PE RVU: 7.16
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93888 **Transcranial Doppler study of the intracranial arteries; limited study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,532

2021 Work RVU: 0.50
2021 NF PE RVU: 4.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93890 **Transcranial Doppler study of the intracranial arteries; vasoreactivity study** **Global:** XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 52,137

2021 Work RVU: 1.00
2021 NF PE RVU: 7.28
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93892 **Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection**

Global: XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:**

First Identified: October 2019

2019 est Medicare Utilization: 55,222

2021 Work RVU: 1.15
2021 NF PE RVU: 8.14
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Screen

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

93895 **Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral**

Global: XXX **Issue:** Carotid Intima-Media Thickness Ultrasound **Screen:** New Code in CPT 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 37 **Specialty Developing Recommendation:** No Interest

First Identified: April 2014

2019 est Medicare Utilization:

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Rescind April 2014 recommendation, contractor price.

Referred to CPT

Result: Not Part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

93922 **Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC

First Identified: October 2008

2019 est Medicare Utilization: 694,382

2021 Work RVU: 0.25
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.25

Referred to CPT February 2010

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93923 **Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 440,595

2021 Work RVU: 0.45
2021 NF PE RVU: 3.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93924 **Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,266

2021 Work RVU: 0.50
2021 NF PE RVU: 4.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93925 **Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 661,535

2021 Work RVU: 0.80
2021 NF PE RVU: 6.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93926 **Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 262,918

2021 Work RVU: 0.50
2021 NF PE RVU: 3.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93930 **Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** November 2013 **2019 est Medicare Utilization:** 23,417

2021 Work RVU: 0.80
2021 NF PE RVU: 5.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93931 **Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 47,500

2021 Work RVU: 0.50
2021 NF PE RVU: 3.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93965 **Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)**

Global: **Issue:** Non-invasive Physiologic Studies of Extremity Veins **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 47 **Specialty Developing Recommendation:** ACC, ACR, SCAI, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93970 **Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,626,806

2021 Work RVU: 0.70
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93971 **Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** Low Value-High Volume / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, SVS, ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,753,619

2021 Work RVU: 0.45
2021 NF PE RVU: 3.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93975 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, SVS, ACC **First Identified:** November 2013 **2019 est Medicare Utilization:** 218,302

2021 Work RVU: 1.16
2021 NF PE RVU: 6.85
2021 Fac PE RVU: NA

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93976 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 173,269

2021 Work RVU: 0.80
2021 NF PE RVU: 3.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93978 **Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:**

First Identified: April 2013 **2019 est Medicare Utilization:** 287,616

2021 Work RVU: 0.80
2021 NF PE RVU: 4.61
2021 Fac PE RVU: NA

RUC Recommendation: 0.97 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93979 **Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:**

First Identified: October 2013 **2019 est Medicare Utilization:** 66,512

2021 Work RVU: 0.50
2021 NF PE RVU: 3.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93982 **Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS

First Identified: January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93985 **Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study**

Global: XXX **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.80
2021 NF PE RVU: 6.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93986 **Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study**

Global: XXX **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 3.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93990 **Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)**

Global: XXX **Issue:** Doppler Flow Testing **Screen:** CMS Fastest Growing / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 40 **Specialty Developing Recommendation:** ACR, SVS

First Identified: October 2008 **2019 est Medicare Utilization:** 132,133

2021 Work RVU: 0.50
2021 NF PE RVU: 3.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94010 **Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation**

Global: XXX **Issue:** Spirometry **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 12 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,234,541

2021 Work RVU: 0.17
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

94014 **Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 47

2021 Work RVU: 0.52
2021 NF PE RVU: 1.07
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94015 **Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 38

2021 Work RVU: 0.00
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94016 **Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** April 2008 **2019 est Medicare Utilization:** 5,244

2021 Work RVU: 0.52
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.18

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94060 **Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration**

Global: XXX **Issue:** Spirometry **Screen:** MPC List / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 12 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,160,195

2021 Work RVU: 0.22
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.22

Referred to CPT

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94200 **Maximum breathing capacity, maximal voluntary ventilation**

Global: XXX **Issue:** Lung Function Test **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 28 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2019 est Medicare Utilization:** 74,436

2021 Work RVU: 0.05
2021 NF PE RVU: 0.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.05

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94240 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94250 **Expired gas collection, quantitative, single procedure (separate procedure)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 20,825

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94260 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 / **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94350 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94360 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94370 **Determination of airway closing volume, single breath tests**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94400 **Breathing response to CO2 (CO2 response curve)** **Global:** XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** **2019 est Medicare Utilization:** 1,310

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94450 **Breathing response to hypoxia (hypoxia response curve)** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 56

2021 Work RVU: 0.40
2021 NF PE RVU: 1.35
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94617 **Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)** **Global:** XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2016 **2019 est Medicare Utilization:** 9,892

2021 Work RVU: 0.70
2021 NF PE RVU: 1.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94618 **Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2016 **2019 est Medicare Utilization:** 271,019

2021 Work RVU: 0.48
2021 NF PE RVU: 0.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94620 **Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)**

Global: **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94621 **Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** January 2016 **2019 est Medicare Utilization:** 21,378

2021 Work RVU: 1.42
2021 NF PE RVU: 3.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.42 **Referred to CPT** February 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94640 **Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 /CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** AAFP, ATS, CHEST, **First Identified:** **2019 est Medicare Utilization:** 601,038

2021 Work RVU: 0.00
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94667 **Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2019 **2019 est Medicare Utilization:** 6,331

2021 Work RVU: 0.00
2021 NF PE RVU: 0.61
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94668 **Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** AAFP, ATS, CHEST, **First Identified:** **2019 est Medicare Utilization:** 5,171

2021 Work RVU: 0.00
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs CPT Assistant article published **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

Status Report: CMS Requests and Relativity Assessment Issues

94669 **Mechanical chest wall oscillation to facilitate lung function, per session** **Global:** XXX **Issue:** Evaluation of Wheezing **Screen:** CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2019 **2019 est Medicare Utilization:** 324

2021 Work RVU: 0.00
2021 NF PE RVU: 0.65
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94681 **Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AACE, TES, ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 7,816

2021 Work RVU: 0.20
2021 NF PE RVU: 1.27
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

94720 **Carbon monoxide diffusing capacity (eg, single breath, steady state)** **Global:** **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94725 **Membrane diffusion capacity**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94726 **Plethysmography for determination of lung volumes and, when performed, airway resistance**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 681,512

2021 Work RVU: 0.26
2021 NF PE RVU: 1.30
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94727 **Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 348,523

2021 Work RVU: 0.26
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94728 **Airway resistance by oscillometry** **Global:** XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,985

2021 Work RVU: 0.26
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94729 **Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,113,315

2021 Work RVU: 0.19
2021 NF PE RVU: 1.52
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94750 **Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)** **Global:** XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 18,981

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94760 **Noninvasive ear or pulse oximetry for oxygen saturation; single determination**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2019 est Medicare Utilization:** 29,834

2021 Work RVU: 0.00
2021 NF PE RVU: 0.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

94761 **Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2019 est Medicare Utilization:** 16,501

2021 Work RVU: 0.00
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

94762 **Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)**

Global: XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Fastest Growing, CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** October 2008 **2019 est Medicare Utilization:** 208,171

2021 Work RVU: 0.00
2021 NF PE RVU: 0.78
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94770 **Carbon dioxide, expired gas determination by infrared analyzer**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,724

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

95004 **Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 27 **Specialty Developing Recommendation:** AAAAI, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 10,738,966

2021 Work RVU: 0.01
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95010 **Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95012 **Nitric oxide expired gas determination** **Global:** XXX **Issue:** Exhaled Nitric Oxide Measurement (PE Only) **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 26 **Specialty Developing Recommendation:** AAAAI, ACAAI, ATS, CHEST **First Identified:** October 2018 **2019 est Medicare Utilization:** 136,728

2021 Work RVU: 0.00
2021 NF PE RVU: 0.57
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95015 **Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests** **Global:** **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95017 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests** **Global:** XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 27,662

2021 Work RVU: 0.07
2021 NF PE RVU: 0.17
2021 Fac PE RVU: 0.03

RUC Recommendation: 0.07 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95018 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 129,391

2021 Work RVU: 0.14
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.14 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95024 **Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI, AAOA **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,833,929

2021 Work RVU: 0.01
2021 NF PE RVU: 0.23
2021 Fac PE RVU: 0.01

RUC Recommendation: New PE Inputs. **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95027 **Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 164,524

2021 Work RVU: 0.01
2021 NF PE RVU: 0.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95115 **Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,034,318

2021 Work RVU: 0.00
2021 NF PE RVU: 0.26
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95117 **Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,769,382

2021 Work RVU: 0.00
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95144 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 49 **Specialty Developing Recommendation:** AAOHNS, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 178,622

2021 Work RVU: 0.06
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95148 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms**

Global: XXX **Issue:** **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 73 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 20,261

2021 Work RVU: 0.06
2021 NF PE RVU: 2.59
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95165 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 49 **Specialty Developing Recommendation:** AAOHNS, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 7,687,749

2021 Work RVU: 0.06
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95249 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 08 **Specialty Developing Recommendation:** AACE, ES, ACP **First Identified:** **2019 est Medicare Utilization:** 10,730

2021 Work RVU: 0.00
2021 NF PE RVU: 1.64
2021 Fac PE RVU: NA

RUC Recommendation: PE Only. Referral to CPT Assistant **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** June 2018

Status Report: CMS Requests and Relativity Assessment Issues

95250 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACE, ES

First Identified: October 2013 **2019 est Medicare Utilization:** 76,885

2021 Work RVU: 0.00
2021 NF PE RVU: 4.47
2021 Fac PE RVU: NA

RUC Recommendation: Re-review at RAW. New PE inputs.

Referred to CPT October 2015 & February 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95251 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACE, ES

First Identified: April 2013 **2019 est Medicare Utilization:** 248,288

2021 Work RVU: 0.70
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.28

RUC Recommendation: Re-review at RAW. 0.70.

Referred to CPT February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95700 **Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS

First Identified: May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only

Referred to CPT **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95705 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95706 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95707 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95708 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95709 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95710 **Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95711 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95712 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95713 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95714 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95715 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95716 **Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95717 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.00
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.79

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95718 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 1.25
2021 Fac PE RVU: 1.18

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95719 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.00
2021 NF PE RVU: 1.37
2021 Fac PE RVU: 1.32

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95720 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.86
2021 NF PE RVU: 1.91
2021 Fac PE RVU: 1.82

RUC Recommendation: 3.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95721 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.86
2021 NF PE RVU: 1.95
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95722 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.70
2021 NF PE RVU: 2.36
2021 Fac PE RVU: 2.22

RUC Recommendation: 4.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95723 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.75
2021 NF PE RVU: 2.45
2021 Fac PE RVU: 2.28

RUC Recommendation: 4.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95724 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: 2.84

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95725 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 5.40
2021 NF PE RVU: 2.82
2021 Fac PE RVU: 2.61

RUC Recommendation: 5.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95726 **Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.58
2021 NF PE RVU: 3.83
2021 Fac PE RVU: 3.59

RUC Recommendation: 7.58 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95800 **Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 24,715

2021 Work RVU: 0.85
2021 NF PE RVU: 3.98
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95801 **Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 422

2021 Work RVU: 0.85
2021 NF PE RVU: 1.72
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95803 **Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** NA **2019 est Medicare Utilization:** 232

2021 Work RVU: 0.90
2021 NF PE RVU: 3.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 and New PE inputs **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95805 **Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,017

2021 Work RVU: 1.20
2021 NF PE RVU: 10.97
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95806 **Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 80,376

2021 Work RVU: 0.93
2021 NF PE RVU: 1.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95807 **Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,278

2021 Work RVU: 1.28
2021 NF PE RVU: 10.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.25 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95808 **Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 1,197

2021 Work RVU: 1.74
2021 NF PE RVU: 17.45
2021 Fac PE RVU: NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95810 **Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** February 2010 **2019 est Medicare Utilization:** 272,131

2021 Work RVU: 2.50
2021 NF PE RVU: 15.30
2021 Fac PE RVU: NA

RUC Recommendation: 2.50 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95811 **Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 333,381

2021 Work RVU: 2.60
2021 NF PE RVU: 15.99
2021 Fac PE RVU: NA

RUC Recommendation: 2.60 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95812 **Electroencephalogram (EEG) extended monitoring; 41-60 minutes** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 24,822

2021 Work RVU: 1.08
2021 NF PE RVU: 8.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95813 **Electroencephalogram (EEG) extended monitoring; 61-119 minutes** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 31,299

2021 Work RVU: 1.63
2021 NF PE RVU: 10.70
2021 Fac PE RVU: NA

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95816 **Electroencephalogram (EEG); including recording awake and drowsy** **Global:** XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:** 278,212

2021 Work RVU: 1.08
2021 NF PE RVU: 9.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95819 **Electroencephalogram (EEG); including recording awake and asleep** **Global:** XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 202,028

2021 Work RVU: 1.08
2021 NF PE RVU: 12.12
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95822 **Electroencephalogram (EEG); recording in coma or sleep only**

Global: XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 26,955

2021 Work RVU: 1.08
2021 NF PE RVU: 10.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95827 **Electroencephalogram (EEG); all night recording**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:** 5,020

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95831 **Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2015 **2019 est Medicare Utilization:** 79,780

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95832 **Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 11,062

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95833 **Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 867

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95834 **Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 605

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95860 **Needle electromyography; 1 extremity with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges over $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,418

2021 Work RVU: 0.96
2021 NF PE RVU: 2.48
2021 Fac PE RVU: NA

RUC Recommendation: 0.96 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95861 **Needle electromyography; 2 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 44,204

2021 Work RVU: 1.54
2021 NF PE RVU: 3.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.54 **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95863 **Needle electromyography; 3 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 157

2021 Work RVU: 1.87
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.87 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95864 **Needle electromyography; 4 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,620

2021 Work RVU: 1.99
2021 NF PE RVU: 5.25
2021 Fac PE RVU: NA

RUC Recommendation: 1.99 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95867 **Needle electromyography; cranial nerve supplied muscle(s), unilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 1,113

2021 Work RVU: 0.79
2021 NF PE RVU: 2.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.79 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95868 **Needle electromyography; cranial nerve supplied muscles, bilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 5,630

2021 Work RVU: 1.18
2021 NF PE RVU: 3.05
2021 Fac PE RVU: NA

RUC Recommendation: 1.18 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95869 **Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2011 **2019 est Medicare Utilization:** 447

2021 Work RVU: 0.37
2021 NF PE RVU: 2.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95870 **Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2011 **2019 est Medicare Utilization:** 52,835

2021 Work RVU: 0.37
2021 NF PE RVU: 2.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95885 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 141,249

2021 Work RVU: 0.35
2021 NF PE RVU: 1.59
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95886 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 962,501

2021 Work RVU: 0.86
2021 NF PE RVU: 2.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.92 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95887 **Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,870

2021 Work RVU: 0.71
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95900 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** MPC List / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011& February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95903 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 and February 2012 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95904 **Nerve conduction, amplitude and latency/velocity study, each nerve; sensory**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95907 **Nerve conduction studies; 1-2 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 6,263

2021 Work RVU: 1.00
2021 NF PE RVU: 1.73
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95908 **Nerve conduction studies; 3-4 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 58,348

2021 Work RVU: 1.25
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.37 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95909 **Nerve conduction studies; 5-6 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 134,007

2021 Work RVU: 1.50
2021 NF PE RVU: 2.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.77 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95910 **Nerve conduction studies; 7-8 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 157,766

2021 Work RVU: 2.00
2021 NF PE RVU: 3.41
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95911 **Nerve conduction studies; 9-10 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 175,960

2021 Work RVU: 2.50
2021 NF PE RVU: 4.00
2021 Fac PE RVU: NA

RUC Recommendation: 3.34 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95912 **Nerve conduction studies; 11-12 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 78,978

2021 Work RVU: 3.00
2021 NF PE RVU: 4.50
2021 Fac PE RVU: NA

RUC Recommendation: 4.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95913 **Nerve conduction studies; 13 or more studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 81,707

2021 Work RVU: 3.56
2021 NF PE RVU: 5.15
2021 Fac PE RVU: NA

RUC Recommendation: 4.20 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95921 **Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 / Different Performing Specialty from Survey3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:** 54,178

2021 Work RVU: 0.90
2021 NF PE RVU: 1.66
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.90 **Referred to CPT** February 2012 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95922 **Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** High Volume Growth1 / CMS Fastest Growing / Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,986

2021 Work RVU: 0.96
2021 NF PE RVU: 2.08
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.96 **Referred to CPT** February 2012 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2008; Sep 2020

95923 **Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** October 2019 **2019 est Medicare Utilization:** 114,086

2021 Work RVU: 0.90
2021 NF PE RVU: 2.88
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

Status Report: CMS Requests and Relativity Assessment Issues

95924 **Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** **2019 est Medicare Utilization:** 21,055

2021 Work RVU: 1.73
2021 NF PE RVU: 2.58
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 1.73 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95925 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,861

2021 Work RVU: 0.54
2021 NF PE RVU: 4.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95926 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1/ CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,658

2021 Work RVU: 0.54
2021 NF PE RVU: 3.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 36 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 325

2021 Work RVU: 1.50
2021 NF PE RVU: 5.39
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 36 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,333

2021 Work RVU: 1.50
2021 NF PE RVU: 5.60
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95930 **Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report**

Global: XXX **Issue:** Visual Evoked Potential Testing **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 11 **Specialty Developing Recommendation:** AAO, AOA (optometry), ACNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 53,881

2021 Work RVU: 0.35
2021 NF PE RVU: 1.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** May 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95934 **H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95936 **H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95938 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** January 2013 **2019 est Medicare Utilization:** 90,204

2021 Work RVU: 0.86

2021 NF PE RVU: 9.64

2021 Fac PE RVU: NA

RUC Recommendation: 0.86 and new PE inputs **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95939 **Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** January 2013 **2019 est Medicare Utilization:** 41,818

2021 Work RVU: 2.25
2021 NF PE RVU: 13.62
2021 Fac PE RVU: NA

RUC Recommendation: 2.25 and new PE inputs **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95940 **Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:** 25,807

2021 Work RVU: 0.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.60 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95941 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)**

Global: XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95943 **Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** January 2018 **2019 est Medicare Utilization:** 22,723

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95950 **Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2019 est Medicare Utilization:** 2,415

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95951 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 188,070

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95953 **Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2019 est Medicare Utilization:** 24,927

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95954 **Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)**

Global: XXX **Issue:** EEG Monitoring **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 623

2021 Work RVU: 2.45
2021 NF PE RVU: 8.95
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

95956 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 5,307

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Status Report: CMS Requests and Relativity Assessment Issues

95957 **Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)** **Global:** XXX **Issue:** Electroencephalogram (EEG) Exended Monitoring **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 50 **Specialty Developing Recommendation:** AAN **First Identified:** July 2015 **2019 est Medicare Utilization:** 61,055

2021 Work RVU: 1.98
2021 NF PE RVU: 5.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.98 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95970 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming** **Global:** XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 / High Volume Growth3 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 38,689

2021 Work RVU: 0.35
2021 NF PE RVU: 0.17
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.45 **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95971 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional** **Global:** XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 21,590

2021 Work RVU: 0.78
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.78 **Referred to CPT** February 2015, June 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95972 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 46,946

2021 Work RVU: 0.80
2021 NF PE RVU: 0.76
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.80 **Referred to CPT** May 2014 February , June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95973 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 21 **Specialty Developing Recommendation:** AANS/CNS, ACOG, ASA, AUA, ISIS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95974 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95975 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

Status Report: CMS Requests and Relativity Assessment Issues

95976 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 8,660

2021 Work RVU: 0.73
2021 NF PE RVU: 0.38
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.95 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

95977 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 7,130

2021 Work RVU: 0.97
2021 NF PE RVU: 0.50
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.19 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

Status Report: CMS Requests and Relativity Assessment Issues

95978 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95979 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95980 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 570

2021 Work RVU: 0.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.35

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95981 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 843

2021 Work RVU: 0.30
2021 NF PE RVU: 0.73
2021 Fac PE RVU: 0.17

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95982 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,278

2021 Work RVU: 0.65
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.31

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95983 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 40,522

2021 Work RVU: 0.91
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.25 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

Status Report: CMS Requests and Relativity Assessment Issues

95984 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 58,079

2021 Work RVU: 0.80
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.40

RUC Recommendation: 1.00 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

95990 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** April 2010 **2019 est Medicare Utilization:** 1,124

2021 Work RVU: 0.00
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95991 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 07 **Specialty Developing Recommendation:** ASA, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:** 8,596

2021 Work RVU: 0.77
2021 NF PE RVU: 2.50
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.77 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95992 **Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day**

Global: XXX **Issue:** **Screen:** Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2019 est Medicare Utilization:** 112,529

2021 Work RVU: 0.75
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.28

RUC Recommendation: Remove from Modifier -51 Exempt list. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96101 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96102 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96103 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96105 **Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS Request/Speech Language Pathology Request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 1,273

2021 Work RVU: 1.75
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96110 **Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96111 **Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96112 **Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 1,417

2021 Work RVU: 2.56
2021 NF PE RVU: 1.07
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96113 **Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 132

2021 Work RVU: 1.16
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.10 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96116 **Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:** 157,733

2021 Work RVU: 1.86
2021 NF PE RVU: 0.83
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.86 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96118 **Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96119 **Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96120 **Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96121 **Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 47,794

2021 Work RVU: 1.71
2021 NF PE RVU: 0.56
2021 Fac PE RVU: 0.33

RUC Recommendation: 1.71 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96125 **Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 4,262

2021 Work RVU: 1.70
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 1.70 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96127 **Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 492,372

2021 Work RVU: 0.00
2021 NF PE RVU: 0.13
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96130 **Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 99,759

2021 Work RVU: 2.56
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.44

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96131 **Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 80,133

2021 Work RVU: 1.96
2021 NF PE RVU: 0.57
2021 Fac PE RVU: 0.29

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96132 **Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 194,323

2021 Work RVU: 2.56
2021 NF PE RVU: 1.16
2021 Fac PE RVU: 0.38

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96133 **Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 339,426

2021 Work RVU: 1.96
2021 NF PE RVU: 0.96
2021 Fac PE RVU: 0.27

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96136 **Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 173,801

2021 Work RVU: 0.55
2021 NF PE RVU: 0.75
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.55 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96137 **Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 379,620

2021 Work RVU: 0.46
2021 NF PE RVU: 0.72
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.46 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96138 **Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 157,925

2021 Work RVU: 0.00
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96139 **Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 353,021

2021 Work RVU: 0.00
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96146 **Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 27,702

2021 Work RVU: 0.00
2021 NF PE RVU: 0.05
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96150 **Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 54,601

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96151 **Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 10,113

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96152 **Health and behavior intervention, each 15 minutes, face-to-face; individual**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 103,595

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96153 **Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 42,795

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96154 **Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** APA (psychology), NASW **First Identified:** April 2017 **2019 est Medicare Utilization:** 8,583

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96155 **Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96156 **Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.10
2021 NF PE RVU: 0.60
2021 Fac PE RVU: 0.28

RUC Recommendation: 2.10

Referred to CPT September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96158 **Health behavior intervention, individual, face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.45
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.19

RUC Recommendation: 1.45

Referred to CPT September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96159 **Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96164 **Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.21
2021 NF PE RVU: 0.06
2021 Fac PE RVU: 0.03

RUC Recommendation: 0.21 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96165 **Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.10
2021 NF PE RVU: 0.03
2021 Fac PE RVU: 0.01

RUC Recommendation: 0.10 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96167 **Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.55
2021 NF PE RVU: 0.44
2021 Fac PE RVU: 0.20

RUC Recommendation: 1.55 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96168 **Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.55
2021 NF PE RVU: 0.16
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.55 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96170 **Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 0.71
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96171 **Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.54
2021 NF PE RVU: 0.26
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.54 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96360 **Intravenous infusion, hydration; initial, 31 minutes to 1 hour**

Global: XXX **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 25 **Specialty Developing Recommendation:** ASCO, ASH

First Identified: July 2015 **2019 est Medicare Utilization:** 248,266

2021 Work RVU: 0.17
2021 NF PE RVU: 0.85
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96361 **Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 25 **Specialty Developing Recommendation:** ASCO, ASH

First Identified: July 2015 **2019 est Medicare Utilization:** 433,535

2021 Work RVU: 0.09
2021 NF PE RVU: 0.30
2021 Fac PE RVU: NA

RUC Recommendation: 0.09 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96365 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour**

Global: XXX **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,269,889

2021 Work RVU: 0.21
2021 NF PE RVU: 1.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96366 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** April 2013 **2019 est Medicare Utilization:** 558,744

2021 Work RVU: 0.18
2021 NF PE RVU: 0.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96367 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,292,846

2021 Work RVU: 0.19
2021 NF PE RVU: 0.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96368 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** April 2013 **2019 est Medicare Utilization:** 133,379

2021 Work RVU: 0.17
2021 NF PE RVU: 0.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96372 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, AAFP, ACRh **First Identified:** April 2013 **2019 est Medicare Utilization:** 9,458,412

2021 Work RVU: 0.17
2021 NF PE RVU: 0.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96374 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 272,442

2021 Work RVU: 0.18
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96375 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,416,745

2021 Work RVU: 0.10
2021 NF PE RVU: 0.38
2021 Fac PE RVU: NA

RUC Recommendation: 0.10 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96377 **Application of on-body injector (includes cannula insertion) for timed subcutaneous injection**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** should be on N/R LOI just added to track **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH **First Identified:** January 2016 **2019 est Medicare Utilization:** 60,948

2021 Work RVU: 0.17
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Not Part of RAW
Referred to CPT Asst ☐ **Published in CPT Asst:**

96401 **Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 758,701

2021 Work RVU: 0.21
2021 NF PE RVU: 2.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96402 **Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 403,494

2021 Work RVU: 0.19
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96405 **Chemotherapy administration; intralesional, up to and including 7 lesions**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2019 est Medicare Utilization:** 12,359

2021 Work RVU: 0.52
2021 NF PE RVU: 1.95
2021 Fac PE RVU: 0.28

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96406 **Chemotherapy administration; intralesional, more than 7 lesions**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2019 est Medicare Utilization:** 566

2021 Work RVU: 0.80
2021 NF PE RVU: 3.05
2021 Fac PE RVU: 0.45

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96409 **Chemotherapy administration; intravenous, push technique, single or initial substance/drug**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 79,884

2021 Work RVU: 0.24
2021 NF PE RVU: 2.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96411 **Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 165,078

2021 Work RVU: 0.20
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96413 **Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,875,219

2021 Work RVU: 0.28
2021 NF PE RVU: 3.88
2021 Fac PE RVU: NA

RUC Recommendation: 0.28 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96415 **Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2019 est Medicare Utilization:** 891,855

2021 Work RVU: 0.19
2021 NF PE RVU: 0.69
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96416 **Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 20 **Specialty Developing Recommendation:** ACRh, ASCO, ASH **First Identified:** February 2010 **2019 est Medicare Utilization:** 30,942

2021 Work RVU: 0.21
2021 NF PE RVU: 3.92
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96417 **Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2019 est Medicare Utilization:** 388,626

2021 Work RVU: 0.21
2021 NF PE RVU: 1.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 and new PE inputs **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96440 **Chemotherapy administration into pleural cavity, requiring and including thoracentesis**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 60

2021 Work RVU: 2.12
2021 NF PE RVU: 25.94
2021 Fac PE RVU: 1.00

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96567 **Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day**

Global: XXX **Issue:** Photodynamic Therapy **Screen:** High Volume Growth1 / CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 66,951

2021 Work RVU: 0.00
2021 NF PE RVU: 4.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 PE Only **Referred to CPT** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96573 **Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day**

Global: 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** January 2017 **2019 est Medicare Utilization:** 39,219

2021 Work RVU: 0.48
2021 NF PE RVU: 6.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

96574 **Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day**

Global: 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** January 2017 **2019 est Medicare Utilization:** 48,673

2021 Work RVU: 1.01
2021 NF PE RVU: 7.44
2021 Fac PE RVU: NA

RUC Recommendation: 1.01 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96910 **Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B**

Global: XXX **Issue:** Photo-chemotherapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 44 **Specialty Developing Recommendation:** AAD **First Identified:** July 2015 **2019 est Medicare Utilization:** 386,553

2021 Work RVU: 0.00
2021 NF PE RVU: 3.48
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96920 **Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2019 est Medicare Utilization:** 118,570

2021 Work RVU: 1.15
2021 NF PE RVU: 3.56
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.15. Review in two years (Oct 2021) **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

96921 **Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 29,878

2021 Work RVU: 1.30
2021 NF PE RVU: 3.85
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.30. Review in two years (Oct 2021) **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Status Report: CMS Requests and Relativity Assessment Issues

96922 **Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm** **Global:** 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2019 est Medicare Utilization:** 15,528

2021 Work RVU: 2.10
2021 NF PE RVU: 4.86
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.10. Review in two years (Oct 2021) **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

97001 **Physical therapy evaluation** **Global:** **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97002 **Physical therapy re-evaluation** **Global:** **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97003 **Occupational therapy evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97004 **Occupational therapy re-evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97010 **Application of a modality to 1 or more areas; hot or cold packs**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41 **Specialty Developing Recommendation:** No Interest

First Identified: April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.06
2021 NF PE RVU: 0.11
2021 Fac PE RVU: NA

RUC Recommendation: No specialty society interest **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97012 **Application of a modality to 1 or more areas; traction, mechanical**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 560,317

2021 Work RVU: 0.25
2021 NF PE RVU: 0.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97014 **Application of a modality to 1 or more areas; electrical stimulation (unattended)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.18
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97016 **Application of a modality to 1 or more areas; vasopneumatic devices**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 864,521

2021 Work RVU: 0.18
2021 NF PE RVU: 0.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97018 **Application of a modality to 1 or more areas; paraffin bath**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 174,530

2021 Work RVU: 0.06
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97022 **Application of a modality to 1 or more areas; whirlpool**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 193,036

2021 Work RVU: 0.17
2021 NF PE RVU: 0.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97032 **Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** July 2015 **2019 est Medicare Utilization:** 849,666

2021 Work RVU: 0.25
2021 NF PE RVU: 0.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97033 **Application of a modality to 1 or more areas; iontophoresis, each 15 minutes** **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 56,451

2021 Work RVU: 0.26
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97034 **Application of a modality to 1 or more areas; contrast baths, each 15 minutes** **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 8,235

2021 Work RVU: 0.21
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97035 **Application of a modality to 1 or more areas; ultrasound, each 15 minutes** **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,002,641

2021 Work RVU: 0.21
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97110 **Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More-Part1 / MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 60,569,850

2021 Work RVU: 0.45
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97112 **Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 18,084,367

2021 Work RVU: 0.50
2021 NF PE RVU: 0.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97113 **Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,811,269

2021 Work RVU: 0.48
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97116 **Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,661,789

2021 Work RVU: 0.45
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97127 **Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact**

Global: **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 1.50 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97140 **Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 29,711,740

2021 Work RVU: 0.43
2021 NF PE RVU: 0.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97150 **Therapeutic procedure(s), group (2 or more individuals)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** **Specialty Developing Recommendation:** APTA **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,433,348

2021 Work RVU: 0.29
2021 NF PE RVU: 0.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97161 **Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,552,998

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97162 **Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,386,353

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 1.18 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97163 **Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 318,604

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** February 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97164 **Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 585,829

2021 Work RVU: 0.96
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97165 **Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 146,443

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97166 **Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 101,883

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** February 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97167 **Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 22,637

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.70 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97168 **Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 33,480

2021 Work RVU: 0.96
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97530 **Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 20,151,706

2021 Work RVU: 0.44
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97532 **Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes**

Global: **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth2 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA, ASHA, APA (psychology) **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97533 **Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 21,250

2021 Work RVU: 0.48
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97535 **Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,942,480

2021 Work RVU: 0.45
2021 NF PE RVU: 0.50
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Article no longer necessary

---

97537 **Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 23,275

2021 Work RVU: 0.48
2021 NF PE RVU: 0.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97542 **Wheelchair management (eg, assessment, fitting, training), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,278

2021 Work RVU: 0.48
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97597 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less**

Global: 000 **Issue:** Open Wound Debridement **Screen:** Site of Service Anomaly / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 23 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 897,614

2021 Work RVU: 0.77
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.22

RUC Recommendation: 0.88 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97598 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open Wound Debridement **Screen:** Site of Service Anomaly / High Volume Growth3 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 23 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 135,670

2021 Work RVU: 0.50
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97602 **Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** AAOS, ACS, APMA, ASPS **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97605 **Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** AAOS, ACS, APMA, ASPS **First Identified:** April 2013 **2019 est Medicare Utilization:** 51,268

2021 Work RVU: 0.55
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97606 **Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** April 2013 **2019 est Medicare Utilization:** 15,612

2021 Work RVU: 0.60
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97607 **Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2019 est Medicare Utilization:** 5,825

2021 Work RVU: 0.41
2021 NF PE RVU: 9.58
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97608 **Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2019 est Medicare Utilization:** 1,172

2021 Work RVU: 0.46
2021 NF PE RVU: 9.26
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97610 **Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:** 12,331

2021 Work RVU: 0.40
2021 NF PE RVU: 11.52
2021 Fac PE RVU: 0.12

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97755 **Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Tests and Measures **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,693

2021 Work RVU: 0.62
2021 NF PE RVU: 0.47
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

97760 **Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 57,907

2021 Work RVU: 0.50
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97761 **Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,698

2021 Work RVU: 0.50
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97762 **Checkout for orthotic/prosthetic use, established patient, each 15 minutes**

Global: **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97763 **Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 38,754

2021 Work RVU: 0.48
2021 NF PE RVU: 1.08
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97802 **Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2019 est Medicare Utilization:** 224,711

2021 Work RVU: 0.53
2021 NF PE RVU: 0.53
2021 Fac PE RVU: 0.40

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97803 **Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2019 est Medicare Utilization:** 211,418

2021 Work RVU: 0.45
2021 NF PE RVU: 0.46
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98925 **Osteopathic manipulative treatment (OMT); 1-2 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2019 est Medicare Utilization:** 65,014

2021 Work RVU: 0.46
2021 NF PE RVU: 0.42
2021 Fac PE RVU: 0.20

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98926 **Osteopathic manipulative treatment (OMT); 3-4 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2019 est Medicare Utilization:** 109,622

2021 Work RVU: 0.71
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.28

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98927 **Osteopathic manipulative treatment (OMT); 5-6 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2019 est Medicare Utilization:** 99,716

2021 Work RVU: 0.96
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98928 **Osteopathic manipulative treatment (OMT); 7-8 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA

First Identified: February 2010 **2019 est Medicare Utilization:** 99,045

2021 Work RVU: 1.21
2021 NF PE RVU: 0.81
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98929 **Osteopathic manipulative treatment (OMT); 9-10 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA

First Identified: February 2010 **2019 est Medicare Utilization:** 76,576

2021 Work RVU: 1.46
2021 NF PE RVU: 0.94
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98940 **Chiropractic manipulative treatment (CMT); spinal, 1-2 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011 **2019 est Medicare Utilization:** 5,600,246

2021 Work RVU: 0.46
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98941 **Chiropractic manipulative treatment (CMT); spinal, 3-4 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011 **2019 est Medicare Utilization:** 13,626,398

2021 Work RVU: 0.71
2021 NF PE RVU: 0.44
2021 Fac PE RVU: 0.26

RUC Recommendation: 0.71 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98942 **Chiropractic manipulative treatment (CMT); spinal, 5 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA **First Identified:** September 2011 **2019 est Medicare Utilization:** 948,986

2021 Work RVU: 0.96
2021 NF PE RVU: 0.54
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.96 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98943 **Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions**

Global: XXX **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU: 0.46
2021 NF PE RVU: 0.29
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99143 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99144 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99148 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99149 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99150 **Deleted from CPT**

Global: **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99151 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 11

2021 Work RVU: 0.50
2021 NF PE RVU: 1.99
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99152 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,909,615

2021 Work RVU: 0.25
2021 NF PE RVU: 1.24
2021 Fac PE RVU: 0.09

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

99155 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 30

2021 Work RVU: 1.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.32

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99156 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older**

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 7,955

2021 Work RVU: 1.65
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.84 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99174 **Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report**

Global: XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 09 **Specialty Developing Recommendation:** AAP, AAO **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.15
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

99177 **Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis**

Global: XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** May 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.12
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99183 **Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session**

Global: XXX **Issue:** Hyperbaric Oxygen Therapy **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACEP, ACP, ACS, APMA **First Identified:** April 2013 **2019 est Medicare Utilization:** 386,280

2021 Work RVU: 2.11
2021 NF PE RVU: 0.78
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

99281 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 67,730

2021 Work RVU: 0.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99282 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 352,496

2021 Work RVU: 0.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99283 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 2,744,710

2021 Work RVU: 1.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.33

RUC Recommendation: 1.42 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99284 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 5,415,650

2021 Work RVU: 2.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.54

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99285 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 11,514,274

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.75

RUC Recommendation: 3.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99358 **Prolonged evaluation and management service before and/or after direct patient care; first hour**

Global: XXX **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 12 **Specialty Developing Recommendation:** AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE **First Identified:** November 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 2.10
2021 NF PE RVU: 0.95
2021 Fac PE RVU: 0.95

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

99359 **Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)**

Global: ZZZ **Issue:** Prolonged Services **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 12 **Specialty Developing Recommendation:** AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE **First Identified:** November 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.00
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.47

RUC Recommendation: Refer to CPT **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99363 **Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)**

Global: **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:**

First Identified: September 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

99364 **Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)**

Global: **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:**

First Identified: September 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99375 **Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.67

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

99378 **Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.67

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99491 **Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.**

Global: XXX **Issue:** Chronic Care Management Services **Screen:** New and Revised Service (Not part of RAW) **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 09 **Specialty Developing Recommendation:** AAFP, AAN, ACP, AGS **First Identified:** NA **2019 est Medicare Utilization:** 48,091

2021 Work RVU: 1.45
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.45. Refer to CPT Assistant

Referred to CPT **Result:** Not part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2018

99492 **Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 16,445

2021 Work RVU: 1.88
2021 NF PE RVU: 2.41
2021 Fac PE RVU: 0.68

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99493 **Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 14,660

2021 Work RVU: 2.05
2021 NF PE RVU: 2.24
2021 Fac PE RVU: 0.76

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

99494 **Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 27,335

2021 Work RVU: 0.82
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.30

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99497 **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate**

Global: XXX **Issue:** Advance Care Planning **Screen:** RUC Referral to CPT Assistant **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,825,276

2021 Work RVU: 1.50
2021 NF PE RVU: 0.86
2021 Fac PE RVU: 0.65

RUC Recommendation: Review in 2 years **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

99498 **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Advance Care Planning **Screen:** RUC Referral to CPT Assistant **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 60,204

2021 Work RVU: 1.40
2021 NF PE RVU: 0.64
2021 Fac PE RVU: 0.63

RUC Recommendation: Review in 2 years **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

G0101 **Cervical or vaginal cancer screening; pelvic and clinical breast examination**

Global: XXX **Issue:** **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2010 **2019 est Medicare Utilization:** 929,962

2021 Work RVU: 0.45
2021 NF PE RVU: 0.63
2021 Fac PE RVU: 0.29

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0102 **Prostate cancer screening; digital rectal examination** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 30,358

2021 Work RVU: 0.18
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.07

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0104 **Colorectal cancer screening; flexible sigmoidoscopy** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,724

2021 Work RVU: 0.84
2021 NF PE RVU: 4.65
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.84 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0105 **Colorectal cancer screening; colonoscopy on individual at high risk** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 262,478

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0108 **Diabetes outpatient self-management training services, individual, per 30 minutes** **Global:** XXX **Issue:** Diabetes Management Training **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41iv **Specialty Developing Recommendation:** AND **First Identified:** April 2016 **2019 est Medicare Utilization:** 172,612

2021 Work RVU: 0.90
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0109 **Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes**

Global: XXX **Issue:** Diabetes Management Training **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41iv **Specialty Developing Recommendation:** AND **First Identified:** April 2016 **2019 est Medicare Utilization:** 111,248

2021 Work RVU: 0.25
2021 NF PE RVU: 0.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0121 **Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 215,409

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0124 **Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 47,978

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0127 **Trimming of dystrophic nails, any number**

Global: 000 **Issue:** **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** APMA **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,109,311

2021 Work RVU: 0.17
2021 NF PE RVU: 0.52
2021 Fac PE RVU: 0.04

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0141 **Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 3,666

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0166 **External counterpulsation, per treatment session**

Global: XXX **Issue:** External Counterpulsation **Screen:** CMS-Other - Utilization over 100,000 / CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 14 **Specialty Developing Recommendation:** ACC **First Identified:** April 2016 **2019 est Medicare Utilization:** 95,502

2021 Work RVU: 0.00
2021 NF PE RVU: 3.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 (PE Only) **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0168 **Wound closure utilizing tissue adhesive(s) only**

Global: 000 **Issue:** Wound Closure by Adhesive **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 34 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** July 2016 **2019 est Medicare Utilization:** 44,921

2021 Work RVU: 0.31
2021 NF PE RVU: 3.20
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0179 **Physician re-certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 806,300

2021 Work RVU: 0.45
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0180 **Physician certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,169,998

2021 Work RVU: 0.67
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0181 **Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 386,948

2021 Work RVU: 1.73
2021 NF PE RVU: 1.21
2021 Fac PE RVU: NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0182 **Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 26,148

2021 Work RVU: 1.73
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0202 **Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0204 **Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0206 **Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0237 **Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 40,969

2021 Work RVU: 0.00
2021 NF PE RVU: 0.27
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0238 **Therapeutic procedures to improve respiratory function, other than described by g0237, one on one, face to face, per 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 49,322

2021 Work RVU: 0.00
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0248 **Demonstration, prior to initiation of home inr monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the inr monitor, obtaining at least one blood sample, provision of instructions for reporting home inr test results, and documentation of patient's ability to perform testing and report results**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** January 2016 **2019 est Medicare Utilization:** 23,312

2021 Work RVU: 0.00
2021 NF PE RVU: 1.87
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0249 **Provision of test materials and equipment for home inr monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,211,835

2021 Work RVU: 0.00
2021 NF PE RVU: 1.69
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0250 **Physician review, interpretation, and patient management of home inr testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 185,069

2021 Work RVU: 0.18
2021 NF PE RVU: 0.04
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0268 **Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing**

Global: 000 **Issue:** Removal of Impacted Cerumen **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 35 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 166,164

2021 Work RVU: 0.61
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0270 **Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ADA **First Identified:** February 2008 **2019 est Medicare Utilization:** 81,177

2021 Work RVU: 0.45
2021 NF PE RVU: 0.46
2021 Fac PE RVU: 0.34

RUC Recommendation: Maintain/Remove from screen **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0279 **Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)**

Global: ZZZ **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** **First Identified:** October 2017 **2019 est Medicare Utilization:** 783,467

2021 Work RVU: 0.60
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: Recommend CMS delete **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0283 **Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Electrical Stimulation Other than Wound **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2019 est Medicare Utilization:** 7,523,149

2021 Work RVU: 0.18
2021 NF PE RVU: 0.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0296 **Counseling visit to discuss need for lung cancer screening using low dose ct scan (ldct) (service is for eligibility determination and shared decision making)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:** 50,164

2021 Work RVU: 0.52
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.20

RUC Recommendation: Submit action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G0297 **Low dose ct scan (ldct) for lung cancer screening**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:** 260,400

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Recommend CMS delete. Cat I code created.

Referred to CPT May 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

G0364 **Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:**

First Identified: October 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

G0365 **Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)**

Global: **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 38,289

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0389 **Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (aaa) screening**

Global: **Issue:** Abdominal Aorta Ultrasound Screening **Screen:** Final Rule for 2015 / High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 12 **Specialty Developing Recommendation:** ACC, ACP, ACR, SCAI, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: CPT Assistant article published **Referred to CPT** May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2017

G0396 **Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** AAFP, ASA, ASAM **First Identified:** October 2017 **2019 est Medicare Utilization:** 51,068

2021 Work RVU: 0.65
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.25

RUC Recommendation: Refer to CPT **Referred to CPT** Time Uncertain **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0399 **Home sleep test (hst) with type iii portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ecg/heart rate and 1 oxygen saturation**

Global: XXX **Issue:** **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 112,455

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: CMS delete **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0402 **Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment**

Global: XXX **Issue:** Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 526,509

2021 Work RVU: 2.60
2021 NF PE RVU: 2.11
2021 Fac PE RVU: 1.14

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0403 **Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report**

Global: XXX **Issue:** EKG for Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 129,413

2021 Work RVU: 0.17
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0407 **Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 1.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.57

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0408 **Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.82

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX **Issue:** Prostate Biopsy - Pathology **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2014 **2019 est Medicare Utilization:** 133,021

2021 Work RVU: 3.60
2021 NF PE RVU: 6.46
2021 Fac PE RVU: NA

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0422 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring with exercise, per session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 1.70
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 1.43

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0423 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 1.70
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 1.43

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0436 **Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0438 **Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,114,054

2021 Work RVU: 2.60
2021 NF PE RVU: 2.10
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0439 **Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2013 **2019 est Medicare Utilization:** 8,360,475

2021 Work RVU: 1.92
2021 NF PE RVU: 1.78
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0442 **Annual alcohol misuse screening, 15 minutes**

Global: XXX **Issue:** Annual Alcohol Screening **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 893,133

2021 Work RVU: 0.18
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.08

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0444 **Annual depression screening, 15 minutes**

Global: XXX **Issue:** Annual Depression Screening **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,127,052

2021 Work RVU: 0.18
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.08

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0446 **Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes**

Global: XXX **Issue:** Intensive Behavioral Therapy for Cardiovascular Disease **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** October 2017 **2019 est Medicare Utilization:** 253,992

2021 Work RVU: 0.45
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.20

RUC Recommendation: Survey, but no specialty interest, so no recommendation.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0447 **Face-to-face behavioral counseling for obesity, 15 minutes**

Global: XXX **Issue:** Behavioral Counseling for Obesity **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 336,973

2021 Work RVU: 0.45
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.20

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0452 **Molecular pathology procedure; physician interpretation and report**

Global: XXX **Issue:** Molecular Pathology Interpretation **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 128,942

2021 Work RVU: 0.93
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.93

Referred to CPT **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0453 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:**

First Identified: April 2016

2019 est Medicare Utilization: 402,739

2021 Work RVU: 0.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.30

RUC Recommendation: Remove from screen

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0456 **Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters**

Global: **Issue:** Negative Pressure Wound Therapy **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: November 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0457 **Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters**

Global: **Issue:** Negative Pressure Wound Therapy **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: November 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0500 **Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.10
2021 NF PE RVU: 1.57
2021 Fac PE RVU: 0.04

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0506 **Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)**

Global: ZZZ **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.87
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.37

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G6001 **Ultrasonic guidance for placement of radiation therapy fields**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.58
2021 NF PE RVU: 3.88
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G6002 **Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:**

First Identified: October 2017

2019 est Medicare Utilization: 1,291,326

2021 Work RVU: 0.39
2021 NF PE RVU: 1.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

G6012 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization:

2021 Work RVU: 0.00
2021 NF PE RVU: 7.57
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G6013 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization:

2021 Work RVU: 0.00
2021 NF PE RVU: 7.59
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

G6014 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:** 22,014

2021 Work RVU: 0.00
2021 NF PE RVU: 7.57
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

G6015 **Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 11.01
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G6017 **Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg,3d positional tracking, gating, 3d surface tracking), each fraction of treatment**

Global: YYY **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

GPCX1 **Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)**

Global: **Issue:** Visit Complexity E/M Add-On **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 34 **Specialty Developing Recommendation:**

First Identified: November 2019 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: No recommendation on physician work, time or PE for this code. CMS estimates of utilization for code GPC1X should be more conservative.

Referred to CPT **Result:** N/A

Referred to CPT Asst ☐ **Published in CPT Asst:**

P3001 **Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP

First Identified: October 2017 **2019 est Medicare Utilization:** 1,599

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Q0091 **Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** No Specialty Society Interest

First Identified: October 2018 **2019 est Medicare Utilization:** 533,729

2021 Work RVU: 0.37
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.14

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

CPT	2021 Long Descriptor	Issue	Most Recent RUC Mtng Date	Tab	Next RUC Review	RUC or RAW to Review	Specialty Society to Survey
00534	Anesthesia for transver	RAW	January 2019	37			ASA
00537	Anesthesia for cardiac e	Anesthesia for (	October 2020	13			ASA
00560	Anesthesia for procedu	RAW	January 2019	37			ASA
00731	Anesthesia for upper ga	Anesthesia for I	January 2017	04			ASA
00732	Anesthesia for upper ga	Anesthesia for I	January 2017	04			ASA
00740	Anesthesia for upper ga	Anesthesia for I	January 2017	04			ASA
00810	Anesthesia for lower in	Anesthesia for I	January 2017	04			ASA
00811	Anesthesia for lower in	Anesthesia for I	April 2017	04			ASA
00812	Anesthesia for lower in	Anesthesia for I	April 2017	04			ASA
00813	Anesthesia for combine	Anesthesia for I	January 2017	04			ASA
00918	Anesthesia for transure	Anesthesia for t	January 2021	29			
01916	Anesthesia for diagnostic arteriography		October 2020	23	October 2023	RAW	
0191T	Insertion of anterior se	Cataract Remov	January 2021	16			AAO
01930	Anesthesia for therapeu	Anesthesia for I	February 2008	S			ASA
01935	Anesthesia for percutar	Anesthesia Serv	January 2021	04			ASA
01936	Anesthesia for percutar	Anesthesia Serv	January 2021	04			ASA
01937		Anesthesia Serv	January 2021	04			ASA
01938		Anesthesia Serv	January 2021	04			ASA
01939		Anesthesia Serv	January 2021	04			ASA
01940		Anesthesia Serv	January 2021	04			ASA
01941		Anesthesia Serv	January 2021	04			ASA
01942		Anesthesia Serv	January 2021	04			ASA
0275T	Percutaneous laminotomy/laminectom		January 2020	37			
0376T	Insertion of anterior se	Cataract Remov	January 2021	16			AAO
0379T	Visual field assessment, with concurren		January 2020	37	October 2023	RAW	
0394T	High dose rate electronic brachytherap		January 2020	37	October 2023	RAW	
0446T	Creation of subcutaneo	Insertion/ Remo	January 2020	33			AACE, ES
0447T	Removal of implantable	Insertion/ Remo	January 2020	33			AACE, ES
0448T	Removal of implantable	Insertion/ Remo	January 2020	33			AACE, ES
0449T	Insertion of aqueous drainage device, w		January 2020	37			
0474T	Insertion of anterior segment aqueous		January 2020	37			
0509T	Electroretinography (EF	Electroretinogra	January 2021	29	January 2024	RAW	
0671T		Cataract Remov	January 2021	16			AAO
10004	Fine needle aspiration b	Fine Needle Asp	October 2017	04			
10005	Fine needle aspiration b	Fine Needle Asp	January 2020	21			
10006	Fine needle aspiration b	Fine Needle Asp	October 2017	04			
10007	Fine needle aspiration b	Fine Needle Asp	October 2017	04			
10008	Fine needle aspiration b	Fine Needle Asp	October 2017	04			
10009	Fine needle aspiration b	Fine Needle Asp	October 2017	04			
10010	Fine needle aspiration b	Fine Needle Asp	October 2017	04			
10011	Fine needle aspiration b	Fine Needle Asp	January 2018	04			
10012	Fine needle aspiration b	Fine Needle Asp	January 2018	04			
10021	Fine needle aspiration b	Fine Needle Asp	January 2020	21			AACE, ASBS, AS(
10022	Fine needle aspiration;	Fine Needle Asp	October 2017	04			AACE, ASBS, AS(

10030	Image-guided fluid colle	Drainage of Abs	January 2013	04	ACR, SIR
10040	Acne surgery (eg, marsu	Acne Surgery	April 2016	13	AAD
10060	Incision and drainage o	Incision and Dra	October 2010	07	APMA
10061	Incision and drainage o	Incision and Dra	January 2020	37	APMA
10120	Incision and removal of foreign body, su		September 201	12	APMA, AAFP
10180	Incision and drainage, complex, postop		October 2013	18	
11040	Deleted from CPT	Excision and De	September 200	16	APMA, APTA
11041	Deleted from CPT	Excision and De	September 200	16	APMA, APTA
11042	Debridement, subcutan	Excision and De	February 2010	04	APMA, APTA
11043	Debridement, muscle a	Debridement	February 2010	04	APMA, APTA
11044	Debridement, bone (inc	Debridement	February 2010	04	APMA, APTA
11045	Debridement, subcutan	Excision and De	February 2010	04	ACS, APMA, AP
11046	Debridement, muscle a	Debridement	February 2010	04	ACS, APMA, AP
11047	Debridement, bone (inc	Debridement	January 2020	37	ACS, APMA, AP
11055	Paring or cutting of ben	RAW Review	January 2012	30	APMA
11056	Paring or cutting of ben	Trim Skin Lesior	January 2012	53	APMA
11057	Paring or cutting of ben	RAW Review	January 2012	30	APMA
11100	Biopsy of skin, subcutar	Biopsy of Skin L	April 2017	05	AAD
11101	Biopsy of skin, subcutar	Biopsy of Skin L	April 2017	05	AAD
11102	Tangential biopsy of ski	Skin Biopsy	April 2017	05	
11103	Tangential biopsy of ski	Skin Biopsy	April 2017	05	
11104	Punch biopsy of skin (in	Skin Biopsy	April 2017	05	
11105	Punch biopsy of skin (in	Skin Biopsy	April 2017	05	
11106	Incisional biopsy of skin	Skin Biopsy	April 2017	05	
11107	Incisional biopsy of skin	Skin Biopsy	April 2017	05	
11300	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11301	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11302	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11303	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11305	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11306	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11307	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11308	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11310	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11311	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11312	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11313	Shaving of epidermal or	Shaving of Epid	April 2012	38	AAD
11719	Trimming of nondystro	Debridement of	January 2012	32	APMA
11720	Debridement of nail(s)	Debridement of	September 201	53	APMA
11721	Debridement of nail(s)	Debridement of	September 201	53	APMA
11730	Avulsion of nail plate, p	Removal of Nail	January 2016	56	APMA
11750	Excision of nail and nail	Excision of Nail	September 201	26	RUC Review work and di
11752	Excision of nail and nail	Excision of Nail	January 2015	28	
11755	Biopsy of nail unit (eg, p	Biopsy of Nail	April 2017	41i	APMA
11900	Injection, intralesional;	Skin Injection Se	April 2010	31	AAD
11901	Injection, intralesional;	Skin Injection Se	April 2010	31	AAD
11980	Subcutaneous hormone	Drug Delivery Ir	October 2018	05	AAOS, ACOG, A

11981	Insertion, non-biodegra	Drug Delivery Ir	October 2018	05	AAOS, ACOG, A
11982	Removal, non-biodegra	Drug Delivery Ir	October 2018	05	AAOS, ACOG, A
11983	Removal with reinsertic	Drug Delivery Ir	October 2018	05	AAOS, ACOG, A
12001	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12002	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12004	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12005	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12006	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12007	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12011	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12013	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12014	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12015	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12016	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12017	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12018	Simple repair of superfi	Repair of Super	April 2010	32	ACEP, AAFP
12031	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12032	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12034	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12035	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12036	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12037	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12041	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12042	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12044	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12045	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12046	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12047	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12051	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12052	Repair, intermediate, w	Repair of Intern	April 2010	45	AAO-HNS, AAD,
12053	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12054	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12055	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12056	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
12057	Repair, intermediate, w	Repair of Intern	October 2010	22	AAO-HNS, AAD,
13100	Repair, complex, trunk;	Complex Woun	April 2012	37	AAD, AAO-HNS,
13101	Repair, complex, trunk;	Complex Woun	April 2012	37	AAD, AAO-HNS,
13102	Repair, complex, trunk;	Complex Woun	April 2012	37	AAD, AAO-HNS,
13120	Repair, complex, scalp,	Complex Woun	October 2017	19	AAD, AAO-HNS,
13121	Repair, complex, scalp,	Complex Woun	October 2017	19	AAD, AAO-HNS,
13122	Repair, complex, scalp,	Complex Woun	October 2017	19	AAD, AAO-HNS,
13131	Repair, complex, foreh	Complex Woun	April 2012	37	AAD, AAO-HNS,
13132	Repair, complex, foreh	Complex Woun	April 2012	37	AAD, AAO-HNS,
13133	Repair, complex, foreh	Complex Woun	April 2012	37	AAD, AAO-HNS,
13150	Repair, complex, eyelid	Complex Woun	April 2012	37	AAD, AAO-HNS,
13151	Repair, complex, eyelid	Complex Woun	April 2012	37	AAD, AAO-HNS,
13152	Repair, complex, eyelid	Complex Woun	April 2012	37	AAD, AAO-HNS,

13153	Repair, complex, eyelid	Complex Woun	April 2012	37	AAD, AAO-HNS,
14000	Adjacent tissue transfe	Skin Tissue Rea	October 2008	9	ACS, AAD, ASPS
14001	Adjacent tissue transfe	Skin Tissue Rea	October 2008	9	ACS, AAD, ASPS
14020	Adjacent tissue transfe	Skin Tissue Rea	October 2008	9	AAD, ASPS
14021	Adjacent tissue transfe	Skin Tissue Rea	October 2008	9	AAD, ASPS
14040	Adjacent tissue transfe	Skin Tissue Rea	October 2008	9	AAD, ASPS, AAC
14041	Adjacent tissue transfe	Skin Tissue Rea	October 2008	9	AAD, ASPS, AAC
14060	Adjacent tissue transfe	Skin Tissue Rea	October 2008	9	AAD, ASPS, AAC
14061	Adjacent tissue transfe	Skin Tissue Rea	October 2008	9	AAD, ASPS, AAC
14300	Deleted from CPT	Adjacent Tissue	April 2009	04	ACS, AAD, ASPS
14301	Adjacent tissue transfe	Adjacent Tissue	April 2009	04	ACS, AAO-HNS,
14302	Adjacent tissue transfe	Adjacent Tissue	April 2009	04	ACS, AAO-HNS,
15002	Surgical preparation or	RAW	September 201	21	ASPS
15004	Surgical preparation or	RAW	September 201	21	ASPS, APMA
15100	Split-thickness autograf	RAW	September 201	21	ASPS
15120	Split-thickness autograf	Autograft	September 200	16	AAO-HNS, ASPS
15170	Acellular dermal replac	Acellular Derma	February 2010	31	APMA, ASPS
15171	Acellular dermal replac	Acellular Derma	February 2010	31	APMA, ASPS
15175	Acellular dermal replac	Acellular Derma	February 2010	31	APMA, ASPS
15176	Acellular dermal replac	Acellular Derma	February 2010	31	APMA, ASPS
15220	Full thickness graft, free	Skin Graft	September 200	16	AAO-HNS, ASPS
15240	Full thickness graft, free	RAW	September 201	21	ASPS, AAD
15271	Application of skin subs	Chronic Wound	April 2011	04	ACS, APMA, ASF
15272	Application of skin subs	Chronic Wound	April 2011	04	ACS, APMA, ASF
15273	Application of skin subs	Chronic Wound	April 2011	04	ACS, APMA, ASF
15274	Application of skin subs	Chronic Wound	April 2011	04	ACS, APMA, ASF
15275	Application of skin subs	Chronic Wound	April 2011	04	ACS, APMA, ASF
15276	Application of skin subs	Chronic Wound	April 2011	04	ACS, APMA, ASF
15277	Application of skin subs	Chronic Wound	April 2011	04	ACS, APMA, ASF
15278	Application of skin subs	Chronic Wound	April 2011	04	ACS, APMA, ASF
15320	Deleted from CPT	Skin Allograft	February 2010	31	APMA, ASPS
15321	Deleted from CPT	Skin Allograft	February 2010	31	APMA, ASPS
15330	Acellular dermal allogra	Allograft	February 2008	S	ASPS
15331	Deleted from CPT	Acellular Derma	February 2010	31	AAO-HNS, APM
15335	Deleted from CPT	Acellular Derma	February 2010	31	AAO-HNS, APM
15336	Deleted from CPT	Acellular Derma	February 2010	31	AAO-HNS, APM
15360	Deleted from CPT	Tissue Cultured	February 2010	31	APMA, ASPS
15361	Deleted from CPT	Tissue Cultured	February 2010	31	APMA, ASPS
15365	Deleted from CPT	Tissue Cultured	February 2010	31	APMA, ASPS
15366	Deleted from CPT	Tissue Cultured	February 2010	31	APMA, ASPS
15400	Deleted from CPT	Xenograft	September 200	16	APMA, AAO-HN
15401	Deleted from CPT	Xenograft	February 2008	S	ACS, ASPS
15420	Deleted from CPT	Xenograft Skin	February 2010	31	APMA, ASPS, AA
15421	Deleted from CPT	Xenograft Skin	February 2010	31	APMA, ASPS, AA
15570	Formation of direct or t	Skin Pedicle Fla	October 2008	10	ACS, ASPS, AAO
15572	Formation of direct or t	Skin Pedicle Fla	October 2008	10	ACS, ASPS, AAO
15574	Formation of direct or t	Skin Pedicle Fla	October 2008	10	ASPS, AAO-HNS

15576	Formation of direct or t	Skin Pedicle Fla	October 2008	10			ASPS, AAO-HNS
15730	Midface flap (ie, zygom	Muscle Flaps	January 2017	05			AAO
15731	Forehead flap with pres	Muscle Flaps	January 2017	05			
15732	Muscle, myocutaneous	Muscle Flaps	January 2017	05			ASPS
15733	Muscle, myocutaneous	Muscle Flaps	January 2017	05			ASPS
15734	Muscle, myocutaneous	Muscle Flaps	April 2016	14			
15736	Muscle, myocutaneous	Muscle Flaps	April 2016	14			ASSH, ASPS
15738	Muscle, myocutaneous	Muscle Flaps	April 2016	14			ASPS
15740	Flap; island pedicle req	Dermatology ar	April 2008	28			AAD, ASPS
15769	Grafting of autologous	Tissue Grafting	October 2018	04	April 2022	RAW	AAOHNS, ASPS
15771	Grafting of autologous	Tissue Grafting	October 2018	04			ASPS
15772	Grafting of autologous	Tissue Grafting	October 2018	04			ASPS
15773	Grafting of autologous	Tissue Grafting	October 2018	04			ASPS
15774	Grafting of autologous	Tissue Grafting	October 2018	04			ASPS
15777	Implantation of biologic	Chronic Wound	April 2011	04			ACS, APMA, ASF
15823	Blepharoplasty, upper e	Upper Eyelid Bl	April 2010	33			AAO
16020	Dressings and/or debric	Dressings/ Debr	October 2010	08			ASPS, AAFP, AA
16025	Dressings and/or debric	Dressings/ Debr	October 2010	08			ASPS, AAFP, AA
16030	Dressings and/or debric	Dressings/ Debr	April 2010	45			ACEP, ASPS, AA
17000	Destruction (eg, laser s	Destruction of F	April 2013	17			AAD
17003	Destruction (eg, laser s	Destruction of F	April 2013	17			AAD
17004	Destruction (eg, laser s	Destruction of F	April 2013	17			AAD
17106	Destruction of cutaneo	Destruction of S	October 2008	11			AAD
17107	Destruction of cutaneo	Destruction of S	October 2008	11			AAD
17108	Destruction of cutaneo	Destruction of S	October 2008	11			AAD
17110	Destruction (eg, laser s	RAW	October 2013	18			
17111	Destruction (eg, laser s	RAW	October 2013	18			
17250	Chemical cauterization	RAW	October 2019	17	October 2021	RAW	AAFP, ACS, APM
17261	Destruction, malignant	Destruction of M	October 2010	26			AAD, AAFP
17262	Destruction, malignant	Destruction of M	October 2010	26			AAD, AAFP
17271	Destruction, malignant	Destruction of M	October 2010	26			AAD, AAFP
17272	Destruction, malignant	Destruction of M	October 2010	26			AAD, AAFP
17281	Destruction, malignant	Destruction of M	October 2010	26			AAD, AAFP
17282	Destruction, malignant	Destruction of M	October 2010	26			AAD, AAFP
17311	Mohs micrographic tecl	Mohs Surgery	April 2013	18			AAD
17312	Mohs micrographic tecl	Mohs Surgery	April 2013	18			AAD
17313	Mohs micrographic tecl	Mohs Surgery	April 2013	18			AAD
17314	Mohs micrographic tecl	Mohs Surgery	April 2013	18			AAD
17315	Mohs micrographic tecl	Mohs Surgery	April 2013	18			AAD
19020	Mastotomy with explor	Mastotomy	September 200	16			ACS
19081	Biopsy, breast, with pla	Breast Biopsy	April 2013	04			ACR, ACS, ASBS
19082	Biopsy, breast, with pla	Breast Biopsy	April 2013	04			ACR, ACS, ASBS
19083	Biopsy, breast, with pla	Breast Biopsy	April 2013	04			ACR, ACS, ASBS
19084	Biopsy, breast, with pla	Breast Biopsy	April 2013	04			ACR, ACS, ASBS
19085	Biopsy, breast, with pla	Breast Biopsy	April 2013	04			ACR, ACS, ASBS
19086	Biopsy, breast, with pla	Breast Biopsy	April 2013	04			ACR, ACS, ASBS
19102	Biopsy of breast; percu	Breast Biopsy	April 2013	04			ACR, ACS, ASBS

19103	Biopsy of breast; percu	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19281	Placement of breast loc	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19282	Placement of breast loc	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19283	Placement of breast loc	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19284	Placement of breast loc	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19285	Placement of breast loc	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19286	Placement of breast loc	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19287	Placement of breast loc	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19288	Placement of breast loc	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19290	Preoperative placemen	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19291	Preoperative placemen	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19295	Image guided placemer	Breast Biopsy	April 2013	04		ACR, ACS, ASBS
19303	Mastectomy, simple, co	Mastectomy	April 2016	15		ACS, ASBS
19307	Mastectomy, modified	Modified Radica	January 2020	22		
19318	Breast reduction	Mammaplasty	September 200	16		ASPS
19340	Insertion of breast impl	Breast Implant/	January 2020	05		ASPS
19357	Tissue expander placem	Breast Implant/	January 2020	05		ASPS
20000	Deleted from CPT	Incision of Abce	September 200	16		APMA, AAOS
20005	Incision and drainage o	Incision of Deep	October 2017	19		ACS, AAO-HNS
20220	Biopsy, bone, trocar, or	Bone Biopsy Trc	January 2019	22		ACR, SIR
20225	Biopsy, bone, trocar, or	Bone Biopsy Trc	January 2019	22		ACR, SIR
20240	Biopsy, bone, open; sup	Bone Biopsy Exc	January 2016	04		AAOS, APMA
20245	Biopsy, bone, open; dee	Bone Biopsy Exc	January 2016	04		AAOS
20525	Removal of foreign bod	Removal of For	September 200	16		ACS, AAOS
20526	Injection, therapeutic (e	RAW	January 2017	30		
20550	Injection(s); single tend	Injection of Ten	January 2016	27	RUC	AAOS, AAPM&R
20551	Injection(s); single tend	Therapeutic Inje	April 2017	10		AAPMR, AAOS,
20552	Injection(s); single or multiple trigger pc		January 2016	28	RUC	AAPM&R, ACRh
20553	Injection(s); single or multiple trigger pc		January 2016	28	RUC	AAPM&R, ACRh
20600	Arthrocentesis, aspirati	Arthrocentesis	January 2014	04		AAFP, AAOS, AC
20604	Arthrocentesis, aspirati	Arthrocentesis	January 2014	04		AAFP, AAOS, AC
20605	Arthrocentesis, aspirati	Arthrocentesis	January 2014	04		AAFP, AAOS, AC
20606	Arthrocentesis, aspirati	Arthrocentesis	January 2014	04		AAFP, AAOS, AC
20610	Arthrocentesis, aspirati	Arthrocentesis	January 2014	04		AAFP, AAOS, AC
20611	Arthrocentesis, aspirati	Arthrocentesis	January 2014	04		AAFP, AAOS, AC
20612	Aspiration and/or injecti	RAW	January 2017	30		
20680	Removal of implant; de	RAW	September 201	21		AAOS, APMA
20692	Application of a multipl	RAW	April 2014	52		
20694	Removal, under anesth	External Fixatio	September 200	16		AAOS
20700	Manual preparation an	Drug Delivery Ir	October 2018	05		AAOS, AUA
20701	Removal of drug-delive	Drug Delivery Ir	October 2018	05		AAOS, AUA
20702	Manual preparation an	Drug Delivery Ir	October 2018	05		AAOS, AUA
20703	Removal of drug-delive	Drug Delivery Ir	October 2018	05		AAOS, AUA
20704	Manual preparation an	Drug Delivery Ir	October 2018	05		AAOS, AUA
20705	Removal of drug-delive	Drug Delivery Ir	October 2018	05		AAOS, AUA
20900	Bone graft, any donor a	Bone Graft Proc	April 2008	29		AOFAS, AAOS
20902	Bone graft, any donor a	Bone Graft Proc	April 2008	29		AOFAS, AAOS

20926	Tissue grafts, other (eg,	Tissue Grafting	October 2018	04			AAOS, ASPS, AA
21015	Radical resection of tun	Radical Resectic	February 2009	6			ACS, AAOS, AAC
21025	Excision of bone (eg, fo	Excision of Bon	October 2010	61			AAOMS
21495	Open treatment of hyo	Laryngoplasty	January 2016	09		RUC	
21557	Radical resection of tun	Radical Resectic	February 2009	6			ACS, AAOS
21800	Closed treatment of rib	Internal Fixatior	April 2014	05			STS, ACS
21805	Open treatment of rib f	Internal Fixatior	April 2014	05			STS, ACS
21810	Treatment of rib fractu	Internal Fixatior	April 2014	05			STS, ACS
21811	Open treatment of rib f	Internal Fixatior	April 2014	05			STS, ACS
21812	Open treatment of rib f	Internal Fixatior	April 2014	05			STS, ACS
21813	Open treatment of rib f	Internal Fixatior	April 2014	05			STS, ACS
21820	Closed treatment of ste	Internal Fixatior	April 2016	46			AAOS, ACEP, an
21825	Open treatment of ster	Internal Fixatior	April 2014	05			STS, ACS
21935	Radical resection of tun	Radical Resectic	February 2009	6			ACS, AAOS
22214	Osteotomy of spine, po	RAW	September 201	21			AAOS, NASS, AA
22305	Closed treatment of ve	Closed treatme	April 2015	23			AANS/CNS, NAS
22310	Closed treatment of ve	Closed Treatme	January 2020	23	October 2023	RAW	AANS, AAOS, CN
22510	Percutaneous vertebro	Percutaneous V	April 2014	06			AANS, CNS, AAC
22511	Percutaneous vertebro	Percutaneous V	April 2014	06			AANS, CNS, AAC
22512	Percutaneous vertebro	Percutaneous V	April 2014	06			AANS, CNS, AAC
22513	Percutaneous vertebral	Percutaneous V	April 2014	06			AANS, CNS, AAC
22514	Percutaneous vertebral	Percutaneous V	April 2014	06			AANS, CNS, AAC
22515	Percutaneous vertebral	Percutaneous V	April 2014	06			AANS, CNS, AAC
22520	Percutaneous vertebro	Percutaneous V	April 2014	06			AANS, CNS, AAC
22521	Percutaneous vertebro	Percutaneous V	April 2014	06			AANS, CNS, AAC
22522	Percutaneous vertebro	Percutaneous V	April 2014	06			AANS, CNS, AAC
22523	Percutaneous vertebral	Percutaneous V	April 2014	06			AANS, CNS, AAC
22524	Percutaneous vertebral	Percutaneous V	April 2014	06			AANS, CNS, AAC
22525	Percutaneous vertebral	Percutaneous V	April 2014	06			AANS, CNS, AAC
22533	Arthrodesis, lateral extr	Arthrodesis	September 201	51			AAOS, NASS, AA
22551	Arthrodesis, anterior in	Arthrodesis	February 2010	05			NASS, AANS/CN
22552	Arthrodesis, anterior in	Arthrodesis	February 2010	05			NASS, AANS/CN
22554	Arthrodesis, anterior in	Arthrodesis	February 2010	5			NASS, AANS/CN
22558	Arthrodesis, anterior in	Vertebral Corpe	January 2017	30	October 2022	RAW	AANS/CNS, AAC
22585	Arthrodesis, anterior in	Arthrodesis	February 2010	05			NASS, AANS/CN
22612	Arthrodesis, posterior c	Lumbar Arthroc	October 2015	21			AANS/CNS, AAC
22614	Arthrodesis, posterior c	Lumbar Arthroc	February 2011	04			AANS/CNS, AAC
22630	Arthrodesis, posterior i	Lumbar Arthroc	February 2011	04			AANS/CNS, AAC
22632	Arthrodesis, posterior i	Lumbar Arthroc	February 2011	04			AANS/CNS, AAC
22633	Arthrodesis, combined	Lumbar Arthroc	February 2011	04			AANS/CNS, AAC
22634	Arthrodesis, combined	Lumbar Arthroc	February 2011	04			AANS/CNS, AAC
22843	Posterior segmental ins	Spine Fixation D	February 2009	38			AAOS, NASS, AA
22849	Reinsertion of spinal fix	RAW	September 201	21			AAOS, NASS, AA
22851	Application of intervert	Biomechancial I	January 2016	06		RUC	AANS/CNS, NAS
22859	Insertion of interverteb	Biomechancial I	January 2016	06			AAOS, AANS, CN
22867	Insertion of interlamina	Insertion of Inte	January 2021	26			AAOS, AANS, CN
22868	Insertion of interlamina	Biomechancial I	January 2016	06			AAOS, AANS, CN

22900	Excision, tumor, soft tis	Subfascial Excisi	February 2009	5		ACS, AAOS
23076	Excision, tumor, soft tis	Subfascial Excisi	February 2009	5		ACS, AAOS
23120	Claviculectomy; partial	Claviculectomy	April 2008	30		AAOS
23130	Acromioplasty or acron	Removal of Bon	September 200	16		AAOS
23350	Injection procedure for	Injection for Sh	September 201	13		ACR, AAOS
23405	Tenotomy, shoulder are	Tenotomy	September 200	16		AAOS
23410	Repair of ruptured mus	Rotator Cuff	February 2008	12		AAOS
23412	Repair of ruptured mus	Rotator Cuff	September 201	21		AAOS
23415	Coracoacromial ligamer	Shoulder Ligam	October 2010	62		AAOS
23420	Reconstruction of comp	Rotator Cuff	February 2008	12		AAOS
23430	Tenodesis of long tendc	Tenodesis	October 2009	12		AAOS
23440	Resection or transplant	Tendon Transfe	September 200	16		AAOS
23472	Arthroplasty, glenohum	Arthroplasty	October 2015	21		AAOS
23540	Closed treatment of act	PE Subcommitte	April 2016	46		AAOS, ACEP, an
23600	Closed treatment of pro	Treatment of H	September 201	14		AAOS
23625	Closed treatment of gre	PE Subcommitte	April 2016	46		AAOS, ACEP, an
23650	Closed treatment of sho	PE Subcommitte	April 2016	46		AAOS, ACEP and
23655	Closed treatment of sho	PE Subcommitte	April 2016	46		AAOS, ACEP, an
23665	Closed treatment of sho	PE Subcommitte	April 2016	46		AAOS, ACEP, an
24505	Closed treatment of hu	PE Subcommitte	April 2016	46		AAOS, ACEP, an
24600	Treatment of closed elb	PE Subcommitte	April 2016	46		AAOS, ACEP, an
24605	Treatment of closed elb	PE Subcommitte	April 2016	46		AAOS, ACEP, an
25116	Radical excision of burs	Forearm Excisio	October 2010	63		ASSH, AAOS, AS
25210	Carpectomy; 1 bone	Carpectomy	September 200	16		AAOS
25260	Repair, tendon or musc	Tendon Repair	September 200	16		AAOS
25280	Lengthening or shorten	Tendon Repair	September 200	16		AAOS
25310	Tendon transplantation	Forearm Repair	February 2008	15		ASSH, AAOS
25565	Closed treatment of rad	PE Subcommitte	April 2016	46		AAOS, ACEP, an
25605	Closed treatment of dis	PE Subcommitte	April 2016	46		AAOS, ACEP, an
25606	Percutaneous skeletal f	RAW	September 201	21		AAOS, ASSH
25607	Open treatment of dista	RAW	September 201	21		AAOS, ASSH
25608	Open treatment of dista	RAW	September 201	21		AAOS, ASSH
25609	Open treatment of dista	RAW	September 201	21		AAOS, ASSH
25675	Closed treatment of dis	PE Subcommitte	April 2016	46		AAOS, ACEP, an
26020	Drainage of tendon she	Tendon Sheath	April 2018	07		AAOS, ASPS, AS
26055	Tendon sheath incision	Tendon Sheath	April 2018	07		AAOS, ASPS, AS
26080	Arthrotomy, with explo	RAW	October 2015	21	RAW	ASSH, AAOS
26160	Excision of lesion of ten	Tendon Sheath	April 2018	07		AAOS, ASPS, AS
26356	Repair or advancement	Repair Flexor Te	April 2015	25	RUC	AAOS, ASPS, AS
26357	Repair or advancement	Repair Flexor Te	April 2015	25	RUC	AAOS, ASPS, AS
26358	Repair or advancement	Repair Flexor Te	April 2015	25	RUC	AAOS, ASPS, AS
26480	Transfer or transplant c	Tendon Transfe	April 2009	26		AAOS, ASSH
26700	Closed treatment of me	PE Subcommitte	April 2016	46		AAOS, ACEP, an
26750	Closed treatment of dis	PE Subcommitte	April 2016	46		AAOS, ACEP, an
26755	Closed treatment of dis	PE Subcommitte	April 2016	46		AAOS, ACEP, an
26770	Closed treatment of int	PE Subcommitte	April 2016	46		AAOS, ACEP, an
27048	Excision, tumor, soft tis	Excision of Subf	February 2009	05		ACS, AAOS

27062	Excision; trochanteric b	Trochanteric Bu	April 2008	32		AAOS
27096	Injection procedure for	Injection for Sa	April 2011	06		AAPM, AAPMR,
27130	Arthroplasty, acetabula	Hip/Knee Arthr	October 2019	11		AAOS, AAHKS
27134	Revision of total hip art	RAW	September 201	21		AAOS, AAHKS
27193	Closed treatment of pe	Closed Treatme	January 2016	07		AAOS
27194	Closed treatment of pe	Closed Treatme	January 2016	07		AAOS
27197	Closed treatment of po	Closed Treatme	January 2016	07		AAOS
27198	Closed treatment of po	Closed Treatme	January 2016	07		AAOS
27220	Closed treatment of ac	Closed Treatme	April 2018	08		AAOS
27230	Closed treatment of fer	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27232	Closed treatment of fer	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27236	Open treatment of fem	Open Treatmen	October 2012	16		AAOS
27240	Closed treatment of int	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27244	Treatment of intertroch	Treat Thigh Fra	October 2008	12		AAOS
27245	Treatment of intertroch	Treat Thigh Fra	October 2008	12		AAOS
27250	Closed treatment of hip	Closed Treatme	February 2008	18		ACEP
27252	Closed treatment of hip	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27265	Closed treatment of po	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27266	Closed treatment of po	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27279	Arthrodesis, sacroiliac j	Arthodesis - Sa	April 2018	09		AANS, AAOS, CN
27324	Biopsy, soft tissue of th	Soft Tissue Biop	September 200	16		ACS, AAOS
27369	Injection procedure for	Knee Arthrogra	October 2017	05		ACR
27370	Injection of contrast for	Knee Arthrogra	October 2017	05		ACR
27446	Arthroplasty, knee, con	Knee Arthropla	January 2021	27	April 2021	RUC AAOS, AAHKS
27447	Arthroplasty, knee, con	Hip/Knee Arthr	October 2019	11		AAOS, AAHKS
27502	Closed treatment of fer	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27510	Closed treatment of fer	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27550	Closed treatment of kn	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27552	Closed treatment of kn	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27615	Radical resection of tun	Radical Resecio	February 2009	6		ACS, AAOS
27619	Excision, tumor, soft tis	Excision of Subf	February 2009	5		ACS, AAOS
27640	Partial excision (crateri	Leg Bone Resec	February 2008	19		AOFAS, AAOS
27641	Partial excision (crateri	Leg Bone Resec	February 2008	19		AOFAS, AAOS
27650	Repair, primary, open o	Achilles Tendon	February 2008	20		AAOS, AOFAS, A
27654	Repair, secondary, Achi	Achilles Tendon	April 2008	33		AOFAS, APMA,
27685	Lengthening or shorten	Tendon Repair	September 200	16		AAOS
27687	Gastrocnemius recessic	Tendon Repair	September 200	16		AAOS
27690	Transfer or transplant c	Tendon Transfe	April 2008	34		AOFAS, APMA,
27691	Transfer or transplant c	Tendon Transfe	April 2008	34		AOFAS, APMA,
27752	Closed treatment of tib	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27762	Closed treatment of me	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27792	Open treatment of dist	Treatment of A	February 2011	18		AAOS, AOFAS,
27810	Closed treatment of bir	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27814	Open treatment of bim	RAW	September 201	21		AAOS
27818	Closed treatment of tri	Treatment of Fr	April 2016	46		AAOS, ACEP, an
27825	Closed treatment of fra	PE Subcommitt	April 2016	46		AAOS, ACEP, an
27840	Closed treatment of an	PE Subcommitt	April 2016	46		AAOS, ACEP, an

28001	Incision and drainage, b	Treatment of Fc	October 2020	14			AAOS, AOFAS, A
28002	Incision and drainage b	Treatment of Fc	October 2020	14			AAOS, AOFAS, A
28003	Incision and drainage b	Treatment of Fc	October 2020	14			AAOS, AOFAS, A
28111	Ostectomy, complete e	Ostectomy	September 200	16			APMA, AAOS
28120	Partial excision (crateri	Removal of Foo	February 2011	19			AOFAS, APMA,
28122	Partial excision (crateri	Removal of Foo	February 2011	19			AOFAS, APMA,
28124	Partial excision (crateri	Toe Removal	September 200	16			APMA, AAOS
28285	Correction, hammertoe	Orthopaedic Su	October 2010	31			AAOS, AOFAS, A
28289	Hallux rigidus correctio	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28290	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28291	Hallux rigidus correctio	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28292	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28293	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28294	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28295	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28296	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28297	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28298	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28299	Correction, hallux valgu	Bunionectomy	January 2016	08			AAOS, AOFAS, A
28300	Osteotomy; calcaneus (	Osteotomy	September 200	16			AAOS
28310	Osteotomy, shortening,	Osteotomy	September 200	16			APMA, AAOS
28470	Closed treatment of me	Treatment of M	September 201	15			AAOS, APMA, A
28660	Closed treatment of int	PE Subcommitte	April 2016	46			AAOS, ACEP, an
28725	Arthrodesis; subtalar	Foot Arthrodesi	February 2011	20			AOFAS, APMA,
28730	Arthrodesis, midtarsal c	Foot Arthrodesi	February 2011	20			AOFAS, APMA,
28740	Arthrodesis, midtarsal c	Arthrodesis	September 200	16			AAOS
28820	Amputation, toe; meta	Toe Amputatior	April 2019	11			AAOS, ACS, AOF
28825	Amputation, toe; interp	Toe Amputatior	April 2019	11			AAOS, ACS, AOF
29075	Application, cast; elbow	Application of F	September 201	16			AAOS, ASSH
29105	Application of long arm	Application of L	April 2017	11			AAOS, ACEP, AS
29200	Strapping; thorax	Strapping Proce	January 2014	35			APTA
29220	Deleted from CPT	Strapping; low b	April 2008	57			AAFP
29240	Strapping; shoulder (eg	Strapping Proce	January 2014	35			APTA
29260	Strapping; elbow or wri	Strapping Proce	January 2014	35			APTA
29280	Strapping; hand or finge	Strapping Proce	January 2014	35			APTA
29445	Application of rigid tota	Application of R	April 2016	17			AAOS, AHKNS, A
29520	Strapping; hip	Strapping Proce	January 2014	35			APTA
29530	Strapping; knee	Strapping Proce	January 2014	35			APTA
29540	Strapping; ankle and/or	Strapping Lowe	April 2017	41ii			APMA
29550	Strapping; toes	Strapping Lowe	April 2017	41ii			APMA
29580	Strapping; Unna boot	Strapping Multi	October 2016	13		RUC	ACS, APMA, SVS
29581	Application of multi-lay	Strapping Multi	October 2016	13			ACS, APMA, SVS
29582	Application of multi-lay	New Technolog	October 2015	21			APTA
29583	Application of multi-lay	New Technolog	October 2015	21			APTA
29584	Application of multi-lay	New Technolog	October 2018	27	October 2021	RAW	APTA
29590	Denis-Browne splint str	Dennis-Browne	April 2012	07			APMA
29805	Arthroscopy, shoulder,	Arthroscopy	April 2008	51			AAOS

29822	Arthroscopy, shoulder,	Shoulder Debric	January 2020	11		
29823	Arthroscopy, shoulder,	Shoulder Debric	January 2020	11		
29824	Arthroscopy, shoulder,	RAW	October 2015	21		AAOS
29826	Arthroscopy, shoulder,	RAW	October 2015	21		AAOS
29827	Arthroscopy, shoulder,	RAW	October 2015	21		AAOS
29828	Arthroscopy, shoulder,	RAW	October 2015	21		AAOS
29830	Arthroscopy, elbow, dia	Arthroscopy	April 2008	51		AAOS
29840	Arthroscopy, wrist, diag	Arthroscopy	April 2008	51		AAOS
29870	Arthroscopy, knee, diag	Arthroscopy	October 2009	13		AAOS
29888	Arthroscopically aided a	ACL Repair	April 2008	38		AAOS
29900	Arthroscopy, metacarpo	Arthroscopy	April 2008	51		AAOS
30140	Submucous resection ir	Resection of Inf	October 2016	14	RUC	AAOHNS
30465	Repair of nasal vestibul	Repair Nasal Ste	September 200	16		AAO-HNS
30901	Control nasal hemorrha	Control Nasal H	April 2016	20		AAOHNS
30903	Control nasal hemorrha	Control Nasal H	April 2016	20		AAOHNS
30905	Control nasal hemorrha	Control Nasal H	April 2016	20		AAOHNS
30906	Control nasal hemorrha	Control Nasal H	April 2016	20		AAOHNS
31231	Nasal endoscopy, diagn	Nasal/Sinus Enc	January 2012	19		AAO-HNS
31237	Nasal/sinus endoscopy,	Nasal/Sinus Enc	April 2013	19		AAO-HNS
31238	Nasal/sinus endoscopy,	Nasal/Sinus Enc	April 2013	19		AAO-HNS
31239	Nasal/sinus endoscopy,	Nasal/Sinus Enc	April 2013	19		AAO-HNS
31240	Nasal/sinus endoscopy,	Nasal/Sinus Enc	April 2013	19		AAO-HNS
31241	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31253	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31254	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31255	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31256	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31257	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31259	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31267	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31276	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31287	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31288	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31295	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31296	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31297	Nasal/sinus endoscopy,	Nasal/Sinus Enc	January 2017	07		AAOHNS
31298	Nasal/sinus endoscopy,	Nasal/Sinus Enc	October 2020	24		AAOHNS
31500	Intubation, endotrache	Endotracheal In	October 2018	27		ACEP, ASA
31551	Laryngoplasty; for laryn	Laryngoplasty	January 2016	09		AAOHNS
31552	Laryngoplasty; for laryn	Laryngoplasty	January 2016	09		AAOHNS
31553	Laryngoplasty; for laryn	Laryngoplasty	January 2016	09		AAOHNS
31554	Laryngoplasty; for laryn	Laryngoplasty	January 2016	09		AAOHNS
31571	Laryngoscopy, direct, w	Laryngoscopy	September 200	16		AAO-HNS
31575	Laryngoscopy, flexible; diagnostic		October 2015	08		AAO-HNS
31579	Laryngoscopy, flexible c	Laryngoscopy	October 2015	08		AAO-HNS
31580	Laryngoplasty; for laryn	Laryngoplasty	January 2016	09		AAO-HNS
31582	Laryngoplasty; for laryn	Laryngoplasty	January 2015	09		AAO-HNS

31584	Laryngoplasty; with ope	Laryngoplasty	January 2016	09			AAO-HNS
31587	Laryngoplasty, cricoid s	Laryngoplasty	January 2016	09			AAO-HNS
31588	Laryngoplasty, not othe	Laryngoplasty	January 2016	09			AAO-HNS
31591	Laryngoplasty, medializ	Laryngoplasty	January 2016	09			AAOHNS
31592	Cricotracheal resection	Laryngoplasty	January 2016	09			AAOHNS
31600	Tracheostomy, planned	Tracheostomy	April 2016	21			AAOHNS
31601	Tracheostomy, planned	Tracheostomy	April 2016	21			AAOHNS
31603	Tracheostomy, emerge	Tracheostomy	April 2016	21			AAOHNS
31605	Tracheostomy, emerge	Tracheostomy	April 2016	21			AAOHNS
31610	Tracheostomy, fenestra	Tracheostomy	October 2016	15		RUC	AAOHNS, ACS
31611	Construction of trachec	Speech Prosthe	February 2008	S			AAO-HNS
31620	Endobronchial ultrasou	Endobronchial l	January 2015	05			ACCP, ATS
31622	Bronchoscopy, rigid or f	Bronchial Aspira	January 2015	05			ACCP, ATS
31623	Bronchoscopy, rigid or f	Diagnostic Bron	October 2017	09			ATS, CHEST
31624	Bronchoscopy, rigid or f	Diagnostic Bron	October 2017	09			ATS, CHEST
31625	Bronchoscopy, rigid or f	Endobronchial l	January 2015	05			ATS, CHEST
31626	Bronchoscopy, rigid or f	Endobronchial l	January 2015	05			ACCP, ATS
31628	Bronchoscopy, rigid or f	Endobronchial l	January 2015	05			ACCP, ATS
31629	Bronchoscopy, rigid or f	Endobronchial l	January 2015	05			ACCP, ATS
31632	Bronchoscopy, rigid or f	Endobronchial l	January 2015	05			ACCP, ATS
31633	Bronchoscopy, rigid or f	Endobronchial l	January 2015	05			ACCP, ATS
31645	Bronchoscopy, rigid or f	Bronchial Aspira	October 2016	08		RUC	ATS, CHEST
31646	Bronchoscopy, rigid or f	Bronchial Aspira	October 2016	08		RUC	ATS, CHEST
31652	Bronchoscopy, rigid or f	Endobronchial l	January 2015	05			ATS, ACCP
31653	Bronchoscopy, rigid or f	Endobronchial l	January 2015	05			ATS, ACCP
31654	Bronchoscopy, rigid or f	Bronchial Aspira	January 2015	05			ATS, ACCP
32201	Pneumonostomy; with	Drainage of Abs	January 2013	04			
32405	Biopsy, lung or mediast	Lung Biopsy-CT	April 2019	05			ACR, SIR
32408	Core needle biopsy, lun	Lung Biopsy-CT	April 2019	05			ACR, SIR
32420	Pneumocentesis, punct	Thoracentesis w	September 201	17			ACCP, ACR, ATS
32421	Thoracentesis, punctur	Thoracentesis w	September 201	17			ACCP, ACR, ATS
32422	Thoracentesis with inse	Thoracentesis w	September 201	17			ACCP, ACR, ATS
32440	Removal of lung, pneur	RAW Review	January 2013	34			ACCP, ATS, ACR
32480	Removal of lung, other	RAW Review	January 2013	34			ACCP, ATS, ACR
32482	Removal of lung, other	RAW Review	January 2013	34			ACCP, ATS, ACR
32491	Removal of lung, other	RAW Review	January 2012	30			ACCP, ATS, ACR
32551	Tube thoracostomy, inc	Chest Tube Tho	April 2012	10			ACCP, ATS, ACR
32554	Thoracentesis, needle c	Chest Tube Inte	October 2012	04			ACCP, ACR, ATS
32555	Thoracentesis, needle c	Chest Tube Inte	October 2012	04			ACCP, ACR, ATS
32556	Pleural drainage, percu	Chest Tube Inte	October 2012	04			ACCP, ACR, ATS
32557	Pleural drainage, percu	Chest Tube Inte	October 2012	04			ACCP, ACR, ATS
32663	Thoracoscopy, surgical;	RAW review	January 2013	34			STS
33010	Pericardiocentesis; initi	Pericardiocente	January 2019	04			
33011	Pericardiocentesis; sub	Pericardiocente	January 2019	04			
33015	Tube pericardiostomy	Pericardiocente	January 2019	04			ACC
33016	Pericardiocentesis, incl	Pericardiocente	January 2019	04			
33017	Pericardial drainage wit	Pericardiocente	January 2019	04			

33018	Pericardial drainage wit	Pericardiocente	January 2019	04	
33019	Pericardial drainage wit	Pericardiocente	January 2019	04	
33020	Pericardiotomy for rem	Pericardiotomy	April 2018	10	AATS, STS
33025	Creation of pericardial v	Pericardiotomy	April 2018	10	AATS, STS
33207	Insertion of new or repl	Pacemaker or P	April 2011	10	ACC
33208	Insertion of new or repl	Pacemaker or P	April 2011	10	ACC
33212	Insertion of pacemaker	Pacemaker or P	September 201	04	ACC
33213	Insertion of pacemaker	Pacemaker or P	September 201	04	ACC
33221	Insertion of pacemaker	Pacemaker or P	September 201	04	ACC
33227	Removal of permanent	Pacemaker or P	September 201	04	ACC
33228	Removal of permanent	Pacemaker or P	September 201	04	ACC
33229	Removal of permanent	Pacemaker or P	September 201	04	ACC
33230	Insertion of implantable	Pacemaker or P	September 201	04	ACC
33231	Insertion of implantable	Pacemaker or P	September 201	04	ACC
33233	Removal of permanent	Pacemaker or P	April 2011	10	ACC
33240	Insertion of implantable	Pacemaker or P	September 201	04	ACC
33241	Removal of implantable	Pacemaker or P	April 2011	10	ACC
33249	Insertion or replacemer	Pacemaker or P	April 2011	10	ACC
33262	Removal of implantable	Pacemaker or P	September 201	04	ACC
33263	Removal of implantable	Pacemaker or P	September 201	04	ACC
33264	Removal of implantable	Pacemaker or P	September 201	04	ACC
33282	Implantation of patient	Implantation an	April 2013	20	
33284	Removal of an implanta	Implantation an	April 2013	20	
33405	Replacement, aortic val	Valve Replacem	April 2012	40	STS
33430	Replacement, mitral va	Valve Replacem	April 2012	40	STS
33533	Coronary artery bypass	Valve Replacem	April 2012	40	STS
33620	Application of right and	New Technolog	January 2019	37	STS
33621	Transthoracic insertion	New Technolog	January 2019	37	STS
33622	Reconstruction of comp	New Technolog	January 2019	37	STS
33741	Transcatheter atrial sep	Atrial Septostor	January 2020	13	
33745	Transcatheter intracard	Atrial Septostor	January 2020	13	
33746	Transcatheter intracard	Atrial Septostor	January 2020	13	
33863	Ascending aorta graft, v	Aortic Graft	February 2008	S	STS, AATS
33945	Heart transplant, with c	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33946	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33947	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33948	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33949	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33951	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33952	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33953	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33954	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33956	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33957	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33958	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33959	Extracorporeal membra	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S
33960	Prolonged extracorpore	ECMO-ECLS	April 2014	11	STS, AAP, ACC, S

33961	Prolonged extracorpore	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33962	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33963	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33964	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33965	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33966	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33969	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33984	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33985	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33986	Extracorporeal membra	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33987	Arterial exposure with c	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33988	Insertion of left heart v	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
33989	Removal of left heart v	ECMO-ECLS	April 2014	11		STS, AAP, ACC, S
34701	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34702	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34703	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34704	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34705	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34706	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34707	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34708	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34709	Placement of extension	Endovascular R	January 2017	10		SVS, SIR, STS, A
34710	Delayed placement of c	Endovascular R	January 2017	10		SVS, SIR, STS, A
34711	Delayed placement of c	Endovascular R	January 2017	10		SVS, SIR, STS, A
34712	Transcatheter delivery	Endovascular R	January 2017	10		SVS, SIR, STS, A
34713	Percutaneous access ar	Endovascular R	January 2017	10		SVS, SIR, STS, A
34714	Open femoral artery ex	Endovascular R	January 2017	10		SVS, SIR, STS, A
34715	Open axillary/subclavia	Endovascular R	January 2017	10		SVS, SIR, STS, A
34716	Open axillary/subclavia	Endovascular R	January 2017	10		SVS, SIR, STS, A
34800	Endovascular repair of i	Endovascular R	January 2017	10		AAOHNS
34802	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34803	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34804	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34805	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
34806	Transcatheter placeme	Endovascular R	January 2017	10		SVS, SIR, STS, A
34812	Open femoral artery ex	Endovascular R	January 2017	10		SVS, SIR, STS, A
34820	Open iliac artery expos	Endovascular R	January 2017	10		SVS, SIR, STS, A
34825	Placement of proximal	Endovascular R	January 2017	10		SVS, SIR, STS, A
34826	Placement of proximal	Endovascular R	January 2017	10		SVS, SIR, STS, A
34833	Open iliac artery expos	Endovascular R	January 2017	10		SVS, SIR, STS, A
34834	Open brachial artery ex	Endovascular R	January 2017	10		SVS, SIR, STS, A
34900	Endovascular repair of i	Endovascular R	January 2017	10		SVS, SIR, STS, A
35301	Thromboendarterecton	Thromboendart	January 2013	21		SVS
35450	Transluminal balloon ar	Open and Percu	January 2016	15	RUC	ACR, SIR, SVS
35452	Transluminal balloon ar	Open and Percu	January 2016	15	RUC	ACR, SIR, SVS
35454	Deleted from CPT	Endovascular R	April 2010	07		ACC, ACR, SIR, S
35456	Deleted from CPT	Endovascular R	April 2010	07		ACC, ACR, SIR, S

35458	Transluminal balloon ar	Open and Percu	January 2016	15	RUC	ACR, SIR, SVS
35459	Deleted from CPT	Endovascular R	April 2010	07		ACC, ACR, SIR, S
35460	Transluminal balloon ar	Open and Percu	January 2016	15	RUC	ACR, SIR, SVS
35470	Deleted from CPT	Endovascular R	April 2010	07		ACC, ACR, SIR, S
35471	Transluminal balloon ar	Open and Percu	January 2016	15	RUC	ACR, SIR, SVS
35472	Transluminal balloon ar	Open and Percu	January 2016	15	RUC	ACR, SIR, SVS
35473	Deleted from CPT	Endovascular R	April 2010	07		ACC, ACR, SIR, S
35474	Deleted from CPT	Endovascular R	April 2010	07		ACC, ACR, SIR, S
35475	Transluminal balloon ar	Open and Percu	January 2016	15		ACR, SIR, SVS
35476	Transluminal balloon ar	Open and Percu	January 2016	15	RUC	ACR, SIR, SVS
35490	Deleted from CPT	Endovascular R	April 2010	07		SIR, ACR, SVS
35491	Deleted from CPT	Endovascular R	April 2010	07		SIR, ACR, SVS
35492	Deleted from CPT	Endovascular R	April 2010	07		SIR, ACR, SVS
35493	Deleted from CPT	Endovascular R	April 2010	07		SIR, ACR, SVS
35494	Deleted from CPT	Endovascular R	April 2010	07		SIR, ACR, SVS
35495	Deleted from CPT	Endovascular R	April 2010	07		SIR, ACR, SVS
35701	Exploration not followe	Exploration of A	January 2019	06		ACS, SVS
35702	Exploration not followe	Exploration of A	January 2019	06		
35703	Exploration not followe	Exploration of A	January 2019	06		
35721	Exploration (not follow	Exploration of A	January 2019	06		ACS, SVS
35741	Exploration (not follow	Exploration of A	January 2019	06		ACS, SVS
35761	Exploration (not follow	Exploration of A	January 2019	06		ACS, SVS
36000	Introduction of needle	Introduction of	April 2010	45		ACC, AUR, AAP,
36010	Introduction of cathete	Introduction of	October 2013	18		ACR, SIR, SVS
36140	Introduction of needle	Introduction of	October 2013	18		SVS, SIR, ACR, A
36145	Deleted from CPT	Arteriovenous S	April 2009	9		
36147	Introduction of needle	Dialysis Circuit -	January 2016	14		ACR, RPA, SIR, S
36148	Introduction of needle	Dialysis Circuit -	January 2016	14		ACR, RPA, SIR, S
36215	Selective catheter place	Selective Cathe	April 2016	23		ACR, RPA, SIR, S
36216	Selective catheter place	Selective Cathe	April 2016	23		ACR, SIR, SVS
36217	Selective catheter place	Selective Cathe	April 2016	23		ACR, SIR, SVS
36218	Selective catheter place	Selective Cathe	April 2016	23		ACR, SIR, SVS
36221	Non-selective catheter	Cervicocerebral	April 2012	14		AAN, AANS, ACC
36222	Selective catheter place	Cervicocerebral	April 2012	14		AAN, AANS, ACC
36223	Selective catheter place	Cervicocerebral	October 2020	24		AAN, AANS, ACC
36224	Selective catheter place	Cervicocerebral	October 2020	24		AAN, AANS, ACC
36225	Selective catheter place	Cervicocerebral	April 2012	14		AAN, AANS, ACC
36226	Selective catheter place	Cervicocerebral	April 2012	14		AAN, AANS, ACC
36227	Selective catheter place	Cervicocerebral	April 2012	14		AAN, AANS, ACC
36228	Selective catheter place	Cervicocerebral	April 2012	14		AAN, AANS, ACC
36245	Selective catheter place	Selective Cathe	January 2013	22		ACC, ACR, SIR, S
36246	Selective catheter place	Vascular Injecti	October 2012	27		SVS, SIR, ACR, A
36247	Selective catheter place	Vascular Injecti	October 2012	27		SVS, SIR, ACR, A
36248	Selective catheter place	Catheter Placen	October 2009	40		ACR, SIR
36251	Selective catheter place	Renal Angiogra	April 2011	11		ACR, SIR
36252	Selective catheter place	Renal Angiogra	April 2011	11		ACR, SIR
36253	Superselective catheter	Renal Angiogra	April 2011	11		ACR, SIR

36254	Superselective catheter	Renal Angiogra	April 2011	11			ACR, SIR
36410	Venipuncture, age 3 ye	Venipunture	April 2010	36			ACP
36475	Endovenous ablation th	Endovenous Ab	April 2014	38			ACC, ACR, ACS,
36476	Endovenous ablation th	Endovenous Ab	April 2014	38			ACC, ACR, ACS,
36478	Endovenous ablation th	Endovenous Ab	April 2014	38			ACC, ACR, ACS,
36479	Endovenous ablation th	Endovenous Ab	April 2014	38			ACC, ACR, ACS,
36481	Percutaneous portal ve	Interventional F	February 2009	21			ACR, SIR
36511	Therapeutic apheresis;	Therapeutic Apl	January 2017	12			CAP, RPA
36512	Therapeutic apheresis;	Therapeutic Apl	January 2017	12			CAP, RPA
36513	Therapeutic apheresis;	Therapeutic Apl	January 2017	12			CAP, RPA
36514	Therapeutic apheresis;	Therapeutic Apl	January 2017	12			CAP, RPA
36515	Therapeutic apheresis;	Therapeutic Apl	January 2017	12			CAP, RPA
36516	Therapeutic apheresis;	Therapeutic Apl	January 2017	12			CAP, RPA
36522	Photopheresis, extraco	Therapeutic Apl	January 2017	12			CAP, RPA
36555	Insertion of non-tunnel	Insertion of Cat	October 2016	16		RUC	ACR, ASA
36556	Insertion of non-tunnel	Insertion of Cat	October 2016	16		RUC	ACR, ASA
36568	Insertion of peripherall	PICC Line Proce	January 2018	09	October 2021	RAW	ACR, SIR
36569	Insertion of peripherall	PICC Line Proce	January 2018	09	October 2021	RAW	ACR, SIR
36572	Insertion of peripherall	PICC Line Proce	January 2018	09	October 2021	RAW	
36573	Insertion of peripherall	PICC Line Proce	January 2018	09	October 2021	RAW	
36584	Replacement, complete	PICC Line Proce	January 2018	09	October 2021	RAW	ACR, SIR
36620	Arterial catheterization	Insertion of Cat	April 2018	33			ACR, ASA
36818	Arteriovenous anastom	Arteriovenous A	October 2013	10			ACS, SVS
36819	Arteriovenous anastom	Arteriovenous A	October 2013	10			ACS, SVS
36820	Arteriovenous anastom	Arteriovenous A	October 2013	10			ACS, SVS
36821	Arteriovenous anastom	Arteriovenous A	October 2013	10			ACS, SVS
36822	Insertion of cannula(s) f	ECMO-ECLS	April 2014	11			STS, AAP, ACC, S
36825	Creation of arterioveno	Arteriovenous A	October 2013	10			ACS, SVS
36830	Creation of arterioveno	Arteriovenous A	October 2013	10			ACS, SVS
36834	Deleted from CPT	Aneurysm Repa	September 200	16			AVA, ACS
36870	Thrombectomy, percut	Dialysis Circuit -	January 2016	14		RUC	ACR, SIR, SVS
36901	Introduction of needle(	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
36902	Introduction of needle(	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
36903	Introduction of needle(	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
36904	Percutaneous translum	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
36905	Percutaneous translum	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
36906	Percutaneous translum	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
36907	Transluminal balloon ar	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
36908	Transcatheter placeme	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
36909	Dialysis circuit permane	Dialysis Circuit -	January 2016	14		RUC	ACR, RPA, SIR, S
37183	Revision of transvenous	Interventional F	February 2009	21			ACR, SIR
37191	Insertion of intravascul	IVC Transcathet	April 2011	12			ACR, SIR, SVS
37192	Repositioning of intrava	IVC Transcathet	April 2011	12			ACR, SIR, SVS
37193	Retrieval (removal) of i	IVC Transcathet	April 2011	12			ACR, SIR, SVS
37201	Transcatheter therapy,	Bundle Thromb	April 2012	15			ACR, SIR, SVS
37203	Transcatheter retrieval,	Transcatheter P	September 201	07			ACC, ACR, SIR, S
37204	Transcatheter occlusior	Embolization ar	April 2013	08			ACC, ACR, SIR, S

37205	Transcatheter placeme	Endovascular R	April 2010	07			SVS, ACS, SIR, A
37206	Transcatheter placeme	Endovascular R	April 2010	07			SVS, ACS, SIR, A
37207	Transcatheter placeme	Endovascular R	April 2010	07			SVS, ACS, SIR, A
37208	Transcatheter placeme	Endovascular R	April 2010	07			SVS, ACS, SIR, A
37209	Exchange of a previousl	Bundle Thromb	April 2012	15			ACR, SIR, SVS
37210	Uterine fibroid emboliz	Embolization ar	April 2013	08			ACR, SIR, SVS
37211	Transcatheter therapy,	Bundle Thromb	April 2012	15			ACR, SIR, SVS
37212	Transcatheter therapy,	Bundle Thromb	April 2012	15			ACR, SIR, SVS
37213	Transcatheter therapy,	Bundle Thromb	April 2012	15			ACR, SIR, SVS
37214	Transcatheter therapy,	Bundle Thromb	April 2012	15			ACR, SIR, SVS
37220	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37221	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37222	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37223	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37224	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37225	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37226	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37227	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37228	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37229	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37230	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37231	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37232	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37233	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37234	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37235	Revascularization, endc	Endovascular R	January 2019	37	January 2022	RUC	SVS, ACS, SIR, A
37236	Transcatheter placeme	Transcatheter P	April 2013	09			SVS, ACS, SIR, A
37237	Transcatheter placeme	Transcatheter P	April 2013	09			SVS, ACS, SIR, A
37238	Transcatheter placeme	Transcatheter P	April 2013	09			SVS, ACS, SIR, A
37239	Transcatheter placeme	Transcatheter P	April 2013	09			SVS, ACS, SIR, A
37241	Vascular embolization c	Embolization ar	April 2013	08			SVS, ACS, SIR, A
37242	Vascular embolization c	Embolization ar	April 2013	08			SVS, ACS, SIR, A
37243	Vascular embolization c	Embolization ar	April 2013	08			SVS, ACS, SIR, A
37244	Vascular embolization c	Embolization ar	April 2013	08			SVS, ACS, SIR, A
37246	Transluminal balloon ar	Open and Percu	January 2016	15		RUC	ACR, SIR, SVS
37247	Transluminal balloon ar	Open and Percu	January 2016	15		RUC	ACR, SIR, SVS
37248	Transluminal balloon ar	Open and Percu	January 2016	15		RUC	ACR, SIR, SVS
37249	Transluminal balloon ar	Open and Percu	January 2016	15		RUC	ACR, SIR, SVS
37250	Intravascular ultrasoun	Intravascular Ul	January 2015	07			ACC, SCAI, SIR, S
37251	Intravascular ultrasoun	Intravascular Ul	January 2015	07			ACC,SCAI, SIR, S
37252	Intravascular ultrasoun	Intravascular Ul	October 2018	14			ACC,SCAI, SIR, S
37253	Intravascular ultrasoun	Intravascular Ul	October 2018	14			ACC,SCAI, SIR, S
37609	Ligation or biopsy, tem	Ligation	September 200	16			SVS, ACS
37619	Ligation of inferior vena	Ligation of Infer	April 2011	13			ACS, SVS
37620	Interruption, partial or	Major Vein Revi	April 2010	45			ACR, SIR, SVS
37760	Ligation of perforator v	Perorator Vein	April 2009	10			SVS, ACS
37761	Ligation of perforator v	Perforator Vein	April 2009	10			SVS, ACS

37765	Stab phlebectomy of va	Stab Phlebector	April 2018	12		ACS, SIR, SVS
37766	Stab phlebectomy of va	Stab Phlebector	April 2018	12		ACS, SIR, SVS
37785	Ligation, division, and/c	Ligation	September 200	16		APMA, SVS, ACS
38220	Diagnostic bone marro	Diagnostic Bone	April 2016	06		ASCO, ASH, CAP
38221	Diagnostic bone marro	Diagnostic Bone	April 2016	06		ASCO, ASH, CAP
38222	Diagnostic bone marro	Diagnostic Bone	April 2016	06		ASCO, ASH, CAP
38505	Biopsy or excision of lyr	Needle Biopsy c	October 2020	15		ACR, SIR
38542	Dissection, deep jugula	Jugular Node Di	April 2008	40		ACS, AAO-HNS
38570	Laparoscopy, surgical; v	Laparoscopy Ly	September 201	12		AUA
38571	Laparoscopy, surgical; v	Laparoscopy Ly	September 201	12		AUA
38572	Laparoscopy, surgical; v	Laparoscopy Ly	September 201	12		ACOG
38792	Injection procedure; ra	Radioactive Tra	January 2018	23		
39400	Mediastinoscopy, inclu	Mediastinoscop	January 2015	08		STS
39401	Mediastinoscopy; inclu	Mediastinoscop	January 2015	08		STS
39402	Mediastinoscopy; with	Mediastinoscop	January 2015	08		STS
40490	Biopsy of lip	Biopsy of Lip	September 201	21		AAO-HNS, AAD
40650	Repair lip, full thickness	PE Subcommitt	April 2016	46		AAOS, ACEP, an
40800	Drainage of abscess, cy	RAW	April 2014	52		
40801	Drainage of abscess, cy	Ostectomy	January 2020	37		APMA, AAOS
40808	Biopsy, vestibule of mo	Biopsy of Mout	April 2018	13		AAOHNS, AAOM
40812	Excision of lesion of mu	RAW	April 2014	52		
40820	Destruction of lesion or	RAW	April 2014	52		
41530	Submucosal ablation of	Submucosal abl	April 2015	26	RUC	AAO-HNS
42145	Palatopharyngoplasty (	Palatopharyngo	April 2008	41		AAO-HNS
42415	Excision of parotid tum	Excise Parotid G	February 2011	27		ACS, AAO-HNS
42420	Excision of parotid tum	Excise Parotid G	February 2011	27		ACS, AAO-HNS
42440	Excision of submandibu	Submandibular	October 2010	64		AAO-HNS, ACS
43191	Esophagoscopy, rigid, t	Esophagoscopy	October 2012	10		AAO-HNS, ASGE
43192	Esophagoscopy, rigid, t	Esophagoscopy	October 2012	10		AAO-HNS, ASGE
43193	Esophagoscopy, rigid, t	Esophagoscopy	October 2012	10		AAO-HNS, ASGE
43194	Esophagoscopy, rigid, t	Esophagoscopy	October 2012	10		AAO-HNS, ASGE
43195	Esophagoscopy, rigid, t	Esophagoscopy	October 2012	10		AAO-HNS, ASGE
43196	Esophagoscopy, rigid, t	Esophagoscopy	October 2012	10		AAO-HNS, ASGE
43197	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AAO-HNS, ASGE
43198	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AAO-HNS, ASGE
43200	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AAO-HNS, AGA,
43201	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG
43202	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AAO-HNS, AGA,
43204	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG
43205	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG
43206	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG
43211	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG
43212	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG
43213	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG
43214	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG
43215	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AAO-HNS, AGA,
43216	Esophagoscopy, flexible	Esophagoscopy	October 2012	10		AGA, ASGE, SAG

43217	Esophagoscopy, flexible	Esophagoscopy	October 2012	10	AGA, ASGE, SAG
43219	Esophagoscopy, rigid or	Esophagoscopy	October 2012	10	AGA, ASGE, SAG
43220	Esophagoscopy, flexible	Esophagoscopy	October 2012	10	AGA, ASGE, SAG
43226	Esophagoscopy, flexible	Esophagoscopy	October 2012	10	AAO-HNS, AGA,
43227	Esophagoscopy, flexible	Esophagoscopy	October 2012	10	AGA, ASGE, SAG
43228	Esophagoscopy, rigid or	Esophagoscopy	October 2012	10	AGA, ASGE, SAG
43229	Esophagoscopy, flexible	Esophagoscopy	October 2012	10	AGA, ASGE, SAG
43231	Esophagoscopy, flexible	Esophagoscopy	April 2013	10	AGA, ASGE, SAG
43232	Esophagoscopy, flexible	Esophagoscopy	April 2013	10	AGA, ASGE, SAG
43233	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43234	Upper gastrointestinal e	Esophagoscopy	April 2013	10	AGA, ASGE, SAG
43235	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43236	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43237	Esophagogastroduoden	EGD	April 2013	11	AGA, ASGE, SAG
43238	Esophagogastroduoden	EGD	April 2013	11	AGA, ASGE, SAG
43239	Esophagogastroduoden	EGD with Biops	April 2019	12	ACG, ACS, AGA,
43240	Esophagogastroduoden	EGD	April 2013	11	AGA, ASGE, SAG
43241	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43242	Esophagogastroduoden	EGD	April 2013	11	AGA, ASGE, ACG
43243	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43244	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43245	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43246	Esophagogastroduoden	EGD	April 2013	11	AGA, ASGE, SAG
43247	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43248	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43249	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43250	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43251	Esophagogastroduoden	EGD	April 2013	11	AGA, ASGE, SAG
43253	Esophagogastroduoden	EGD	April 2013	11	AGA, ASGE, SAG
43254	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43255	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43256	Upper gastrointestinal e	EGD	January 2013	08	AGA, ASGE, SAG
43257	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43258	Upper gastrointestinal e	EGD	January 2013	08	AGA, ASGE, SAG
43259	Esophagogastroduoden	EGD	April 2013	11	AGA, ASGE, ACG
43260	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43261	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43262	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43263	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43264	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43265	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43266	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43267	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43268	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43269	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG
43270	Esophagogastroduoden	EGD	January 2013	08	AGA, ASGE, SAG
43271	Endoscopic retrograde	ERCP	April 2013	12	AGA, ASGE, SAG

43272	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE, SAG
43273	Endoscopic cannulation	ERCP	April 2013	12			AGA, ASGE, SAG
43274	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE, SAG
43275	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE, SAG
43276	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE, SAG
43277	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE, SAG
43278	Endoscopic retrograde	ERCP	April 2013	12			AGA, ASGE, SAG
43450	Dilation of esophagus, b	Dilation of Esop	October 2012	17			AGA, ASGE, SAG
43453	Dilation of esophagus, (	Dilation of Esop	October 2012	17			AGA, ASGE, SAG
43456	Dilation of esophagus, b	Dilation of Esop	October 2012	17			AGA, ASGE, SAG
43458	Dilation of esophagus w	Dilation of Esop	October 2012	17			AGA, ASGE, SAG
43760	Change of gastrostomy	Gastrostomy Tu	January 2018	11			ACEP, ACG, ACS
43762	Replacement of gastros	Gastrostomy Tu	January 2018	11	October 2021	RAW	ACEP, ACG, ACS
43763	Replacement of gastros	Gastrostomy Tu	January 2018	11	October 2021	RAW	ACEP, ACG, ACS
44143	Colectomy, partial; with	RAW	January 2016	54			
44205	Laparoscopy, surgical; c	Laproscopic Pro	October 2008	26			ACS, ASCRS
44207	Laparoscopy, surgical; c	Laproscopic Pro	October 2008	26			ACS, ASCRS
44380	Ileoscopy, through ston	IleoscopyIleosc	October 2013	04			AGA, ASGE,ACG
44381	Ileoscopy, through ston	Ileoscopy	October 2013	04			AGA, ASGE,ACG
44382	Ileoscopy, through ston	IleoscopyIleosc	October 2013	04			AGA, ASGE,ACG
44383	Ileoscopy, through ston	Ileoscopy	October 2013	04			AGA, ASGE,ACG
44384	Ileoscopy, through ston	Ileoscopy	October 2013	04			AGA, ASGE,ACG
44385	Endoscopic evaluation (	Pouchoscopy	October 2013	05			ACG, ACS, AGA,
44386	Endoscopic evaluation (	Pouchoscopy	October 2013	05			ACG, ACS, AGA,
44388	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44389	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44390	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44391	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44392	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44393	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44394	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44397	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44401	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44402	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44403	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44404	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44405	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44406	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44407	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44408	Colonoscopy through st	Colonoscopy th	January 2014	08			ASCRS, ACS, SAG
44901	Incision and drainage o	Drainage of Abs	January 2013	04			
44970	Laparoscopy, surgical, a	Laproscopic Pro	October 2008	26			ACS
45170	Deleted from CPT	Rectal Tumor Ex	February 2009	11			ACS, ASCRS, ASG
45171	Excision of rectal tumor	Rectal Tumor Ex	February 2009	11			ACS, ASCRS, ASG
45172	Excision of rectal tumor	Rectal Tumor Ex	February 2009	11			ACS, ASCRS, ASG
45300	Proctosigmoidoscopy, r	Diagnostic Proc	April 2017	13			ACS, ASCRS, SAG
45330	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06			ACG, ACS, AGA,

45331	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45332	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45333	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45334	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45335	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45337	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45338	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45339	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45340	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45341	Sigmoidoscopy, flexible	Flexible Sigmoic	January 2014	09		AGA, ASGE, ACG
45342	Sigmoidoscopy, flexible	Flexible Sigmoic	January 2014	09		AGA, ASGE, ACG
45345	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45346	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45347	Sigmoidoscopy, flexible	Flexible Sigmoic	October 2013	06		ACG, ACS, AGA,
45349	Sigmoidoscopy, flexible	Flexible Sigmoic	April 2014	13		AGA, ASGE, ACG
45350	Sigmoidoscopy, flexible	Flexible Sigmoic	April 2014	13		AGA, ASGE, ACG
45355	Colonoscopy, rigid or fl	Colonoscopy via	January 2014	08		AGA, ASGE, ACG
45378	Colonoscopy, flexible; c	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45379	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45380	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45381	Colonoscopy, flexible; v	Colonoscopy	January 2018	31		AGA, ASGE, ACG
45382	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45383	Colonoscopy, flexible, p	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45384	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45385	Colonoscopy, flexible; v	Colonoscopy	April 2019	13		AGA, ASGE, ACG
45386	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45387	Colonoscopy, flexible, p	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45388	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45389	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45390	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45391	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45392	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45393	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
45398	Colonoscopy, flexible; v	Colonoscopy	January 2014	10		AGA, ASGE, ACG
46020	Placement of seton	Placement/Rem	October 2020	16		ACS, ASCRS (col
46030	Removal of anal seton,	Placement/ Rer	October 2020	16		ACS, ASCRS (col
46200	Fissurectomy, including	Fissurectomy	September 200	16		ACS
46500	Injection of sclerosing s	Hemorrhoid Inj	January 2018	24		ACS, ASCRS (col
47011	Hepatotomy; for percu	Drainage of Abs	January 2013	04		
47135	Liver allotransplantatio	Liver Allotransp	September 201	14		ACS, ASTS
47136	Liver allotransplantatio	RAW	April 2014	52		ACS, ASTS
47382	Ablation, 1 or more live	Interventional F	October 2008	13		ACR, SIR
47490	Cholecystostomy, perc	Cholecystostor	October 2009	04		ACR
47500	Injection procedure for	Percutaneous B	October 2015	06	RUC	ACR, SIR
47505	Injection procedure for	Percutaneous B	October 2015	06	RUC	ACR, SIR
47510	Introduction of percuta	Percutaneous B	October 2015	06	RUC	ACR, SIR
47511	Introduction of percuta	Percutaneous B	October 2015	06	RUC	ACR, SIR

47525	Change of percutaneou	Percutaneous B	October 2015	06			RUC	ACR, SIR
47530	Revision and/or reinser	Percutaneous B	October 2015	06			RUC	ACR, SIR
47531	Injection procedure for	Percutaneous B	October 2015	04			RUC	ACR, SIR
47532	Injection procedure for	Percutaneous B	October 2015	04			RUC	ACR, SIR
47533	Placement of biliary dra	Percutaneous B	October 2015	04			RUC	ACR, SIR
47534	Placement of biliary dra	Percutaneous B	October 2015	04			RUC	ACR, SIR
47535	Conversion of external	Percutaneous B	October 2015	04			RUC	ACR, SIR
47536	Exchange of biliary drai	Percutaneous B	October 2015	04			RUC	ACR, SIR
47537	Removal of biliary drair	Percutaneous B	October 2015	04			RUC	ACR, SIR
47538	Placement of stent(s) ir	Percutaneous B	October 2015	04			RUC	ACR, SIR
47539	Placement of stent(s) ir	Percutaneous B	October 2015	04			RUC	ACR, SIR
47540	Placement of stent(s) ir	Percutaneous B	October 2015	04			RUC	ACR, SIR
47541	Placement of access thr	Percutaneous B	October 2015	04			RUC	ACR, SIR
47542	Balloon dilation of biliar	Percutaneous B	October 2015	04			RUC	ACR, SIR
47543	Endoluminal biopsy(ies)	Percutaneous B	October 2015	04			RUC	ACR, SIR
47544	Removal of calculi/debr	Percutaneous B	October 2015	04			RUC	ACR, SIR
47560	Laparoscopy, surgical; v	RAW	October 2013	18				
47562	Laparoscopy, surgical; c	RAW review	September 201	21				ACS
47563	Laparoscopy, surgical; c	RAW review	October 2013	18				
47600	Cholecystectomy;	Cholecystectom	April 2012	36				ACS, SAGES
47605	Cholecystectomy; with	Cholecystectom	April 2012	36				ACS, SAGES
48102	Biopsy of pancreas, per	Percutaneous N	September 200	16				SIR
48511	External drainage, pseu	Drainage of Abs	January 2013	04				
49021	Drainage of peritoneal a	Drainage of Abs	January 2013	04				ACR, SIR
49041	Drainage of subdiaphra	Drainage of Abs	January 2013	04				ACR, SIR
49061	Drainage of retroperito	Drainage of Abs	January 2013	04				ACR, SIR
49080	Peritoneocentesis, abd	Peritoneocente	October 2010	5				ACR, AGA, ASGE
49081	Peritoneocentesis, abd	Peritoneocente	October 2010	5				ACR, AGA, ASGE
49082	Abdominal paracentesis	Abdominal Para	October 2010	05				ACR, ACS, AGA,
49083	Abdominal paracentesis	Abdominal Para	October 2010	05				ACR, ACS, AGA,
49084	Peritoneal lavage, inclu	Abdominal Para	October 2010	05				ACR, ACS, AGA,
49405	Image-guided fluid colle	Drainage of Abs	January 2013	04				ACR, SIR
49406	Image-guided fluid colle	Drainage of Abs	January 2013	04				ACR, SIR
49407	Image-guided fluid colle	Drainage of Abs	January 2013	04				ACR, SIR
49418	Insertion of tunneled in	Intraperitoneal	April 2010	11				ACS, ACR, SIR
49420	Deleted from CPT	Insertion of Intr	October 2009	40				ACS
49421	Insertion of tunneled in	Intraperitoneal	April 2010	11				ACS, ACR, SIR
49422	Removal of tunneled in	Removal of Intr	April 2017	14				ACS, SVS
49505	Repair initial inguinal he	RAW review	January 2012	30				ACS
49507	Repair initial inguinal he	Hernia Repair	February 2011	29				ACS
49521	Repair recurrent inguin	Hernia Repair	February 2011	29				ACS
49565	Repair recurrent incisio	Repair Recurrer	January 2020	24	April 2021		RUC	ACS, SAGES
49587	Repair umbilical hernia,	Hernia Repair	February 2011	29				ACS
49652	Laparoscopy, surgical, r	Laparoscopic He	February 2011	30				ACS
49653	Laparoscopy, surgical, r	Laparoscopic He	February 2011	30				ACS
49654	Laparoscopy, surgical, r	Laparoscopic He	February 2011	30				ACS
49655	Laparoscopy, surgical, r	Laparoscopic He	February 2011	30				ACS

50021	Drainage of perirenal o	Drainage of Abs	January 2013	04			
50080	Percutaneous nephrost	Percutaneous N	January 2020	25	October 2021	RUC	AUA
50081	Percutaneous nephrost	Percutaneous N	January 2020	25	October 2021	RUC	AUA
50200	Renal biopsy; percutan	Interventional F	October 2008	13			ACR, SIR
50360	Renal allotransplantatic	Renal Allotrans	April 2013	21			ACR, SIR
50387	Removal and replacem	Genitourinary C	January 2015	09			ACR, SIR
50392	Introduction of intracat	Genitourinary C	January 2015	09			ACR, SIR
50393	Introduction of uretera	Genitourinary C	January 2015	09			ACR, SIR
50394	Injection procedure for	Genitourinary C	January 2015	09			ACR, SIR
50395	Introduction of guide in	Dilation of Urin	January 2018	12			ACR, SIR
50398	Change of nephrostom	Genitourinary C	January 2015	09			ACR, SIR
50430	Injection procedure for	Genitourinary C	January 2015	09			ACR, SIR
50431	Injection procedure for	Genitourinary C	January 2015	09			ACR, SIR
50432	Placement of nephrost	Dilation of Urin	January 2018	12			ACR, SIR
50433	Placement of nephrour	Dilation of Urin	January 2018	12			
50434	Convert nephrostomy c	Genitourinary C	January 2015	09			ACR, SIR
50435	Exchange nephrostomy	Genitourinary C	January 2015	09			ACR, SIR
50436	Dilation of existing trac	Dilation of Urin	January 2018	12			
50437	Dilation of existing trac	Dilation of Urin	January 2018	12			
50542	Laparoscopy, surgical; a	Laproscopic Pro	October 2008	26			AUA
50548	Laparoscopy, surgical; r	Laproscopic Pro	October 2008	26			AUA
50590	Lithotripsy, extracorpor	Lithotripsy	April 2012	42			AUA
50605	Ureterotomy for inserti	Ureterotomy	October 2015	21		RAW	AUA, SIR
50606	Endoluminal biopsy of u	Genitourinary C	April 2015	08			ACR, SIR
50693	Placement of ureteral s	Genitourinary C	January 2015	09			ACR, SIR
50694	Placement of ureteral s	Genitourinary C	January 2015	09			ACR, SIR
50695	Placement of ureteral s	Genitourinary C	January 2015	09			ACR, SIR
50705	Ureteral embolization c	Genitourinary C	April 2015	08			ACR, SIR
50706	Balloon dilation, ureter	Genitourinary C	April 2015	08			ACR, SIR
51040	Cystostomy, cystotomy	Cystostomy	September 200	16			AUA
51102	Aspiration of bladder; w	Urological Proc	April 2008	45			AUA
51700	Bladder irrigation, simp	Bladder Cathete	January 2016	32			AUA
51701	Insertion of non-indwel	Bladder Cathete	January 2016	32			AUA
51702	Insertion of temporary	Bladder Cathete	January 2016	32			AUA
51703	Insertion of temporary	Bladder Cathete	January 2016	32			AUA
51720	Bladder instillation of a	Treatment of Bl	January 2016	33			AUA
51726	Complex cystometrogra	Urodynamic Stu	April 2009	16			AUA, ACOG
51727	Complex cystometrogra	Urodynamic Stu	April 2009	16			AUA, ACOG
51728	Complex cystometrogra	Urodynamic Stu	April 2009	16			AUA, ACOG
51729	Complex cystometrogra	Urodynamic Stu	April 2009	16			AUA, ACOG
51736	Simple uroflowmetry (u	Uroflowmetry	October 2010	11			AUA
51741	Complex uroflowmetry	Uroflowmetry	October 2010	11			AUA
51772	Deleted from CPT	Urodynamic Stu	April 2009	16			AUA
51784	Electromyography stud	Electromyograp	January 2019	37			AUA
51792	Stimulus evoked respor	Urinary Reflex S	January 2019	37			AUA
51795	Deleted from CPT	Urology Studies	February 2008	S			
51797	Voiding pressure studie	Urology Studies	February 2008	S			

51798	Measurement of post-v	Voiding Pressur	April 2016	25		AUA
52000	Cystourethroscopy (sep	Cystourethrosc	January 2016	35		AUA, ACOG
52214	Cystourethroscopy, wit	Cystourethrosc	October 2017	19		AUA
52224	Cystourethroscopy, wit	Cystourethrosc	October 2017	19		AUA
52234	Cystourethroscopy, wit	Cystourethrosc	January 2021	29		AUA
52235	Cystourethroscopy, wit	Cystourethrosc	October 2017	19		AUA
52240	Cystourethroscopy, wit	Cystourethrosc	January 2021	29		AUA
52281	Cystourethroscopy, wit	Cystourethrosc	April 2010	38		AUA
52287	Cystourethroscopy, with injection(s) for		January 2020	37		
52332	Cystourethroscopy, wit	Cystourethrosc	April 2013	13		AUA
52334	Cystourethroscopy with	Dilation of Urin	January 2018	12		
52341	Cystourethroscopy; wit	Urological Proc	October 2010	65		AUA
52342	Cystourethroscopy; wit	Urological Proc	October 2010	65		AUA
52343	Cystourethroscopy; wit	Urological Proc	October 2010	65		AUA
52344	Cystourethroscopy with	Urological Proc	October 2010	65		AUA
52345	Cystourethroscopy with	Urological Proc	October 2010	65		AUA
52346	Cystourethroscopy with	Urological Proc	October 2010	65		AUA
52351	Cystourethroscopy, wit	Cystourethrosc	September 201	23		AUA
52352	Cystourethroscopy, wit	Cystourethrosc	September 201	23		AUA
52353	Cystourethroscopy, wit	Cystourethrosc	April 2013	13		AUA
52354	Cystourethroscopy, wit	Cystourethrosc	September 201	23		AUA
52355	Cystourethroscopy, wit	Cystourethrosc	September 201	23		AUA
52356	Cystourethroscopy, wit	Cystourethrosc	April 2013	13		AUA
52400	Cystourethroscopy with	Urological Proc	October 2010	65		AUA
52442	Cystourethroscopy, wit	PE Subcommitt	October 2020	24		AUA, AACU
52500	Transurethral resection	Urological Proc	October 2010	65		AUA
52601	Transurethral electrosu	Transurethral E	April 2016	26		AUA
52640	Transurethral resection	Urological Proc	April 2008	45		AUA
52648	Laser vaporization of pr	Laser Surgery o	April 2008	57		AUA
53445	Insertion of inflatable u	Urological Proc	February 2011	31		AUA
53850	Transurethral destructi	Transurethral D	April 2012	43		AUA
54405	Insertion of multi-comp	Urological Proc	April 2008	45		AUA
54410	Removal and replacem	Urological Proc	February 2011	31		AUA
54520	Orchiectomy, simple (ir	Removal of Tes	September 200	16		AUA
54530	Orchiectomy, radical, fc	Urological Proc	October 2010	65		AUA
55700	Biopsy, prostate; needl	Biopsy of Prosta	January 2016	36		AUA
55706	Biopsies, prostate, nee	RAW	April 2014	52		
55840	Prostatectomy, retropubic radical, with		April 2014	31		AUA
55842	Prostatectomy, retropubic radical, with		April 2014	31		AUA
55845	Prostatectomy, retropu	RAW	April 2014	31		AUA
55866	Laparoscopy, surgical p	Laparoscopic Ra	April 2015	27	RUC	AUA
55873	Cryosurgical ablation of	Cryoablation of	February 2009	25		AUA
55875	Transperineal placemer	RAW	October 2015	21		
56515	Destruction of lesion(s)	Destruction of l	September 200	16		ACOG
56620	Vulvectomy simple; par	Partial Removal	February 2008	D		ACOG
57150	Irrigation of vagina and	Vaginal Treatm	April 2017	15		ACOG
57155	Insertion of uterine tan	RAW	January 2017	30		ACOG, ASTRO

57156	Insertion of a vaginal ra	RAW	January 2017	30	ACOG, ASTRO
57160	Fitting and insertion of	Vaginal Treatm	April 2017	15	ACOG
57240	Anterior colporrhaphy,	Colporrhaphy w	January 2017	14	ACOG
57250	Posterior colporrhaphy,	Colporrhaphy w	January 2017	14	ACOG
57260	Combined anteroposte	Colporrhaphy w	January 2017	14	ACOG
57265	Combined anteroposte	Colporrhaphy w	January 2017	14	ACOG
57282	Colpopexy, vaginal; ext	Colpopexy	January 2020	26	
57283	Colpopexy, vaginal; intr	Colpopexy	January 2020	26	
57287	Removal or revision of	Urological Proc	February 2008	C	AUA
57288	Sling operation for stre	Sling Operation	February 2008	O	ACOG, AUA
57425	Laparoscopy, surgical, c	Laparoscopic Co	January 2020	27	
58100	Endometrial sampling (	Biopsy of Uteru	April 2017	16	ACOG
58110	Endometrial sampling (	Biopsy of Uteru	April 2017	16	ACOG
58555	Hysteroscopy, diagnost	Hysteroscopy	January 2016	37	ACOG
58558	Hysteroscopy, surgical;	Hysteroscopy	January 2016	37	ACOG
58559	Hysteroscopy, surgical;	Hysteroscopy	January 2016	37	ACOG
58560	Hysteroscopy, surgical;	Hysteroscopy	January 2016	37	ACOG
58561	Hysteroscopy, surgical;	Hysteroscopy	January 2016	37	ACOG
58562	Hysteroscopy, surgical;	Hysteroscopy	January 2016	37	ACOG
58563	Hysteroscopy, surgical;	Hysteroscopy	January 2016	37	ACOG
58660	Laparoscopy, surgical; v	Laproscopic Pro	September 200	16	AUA, ACOG
58661	Laparoscopy, surgical; v	Laproscopic Pro	September 200	16	ACOG
58823	Drainage of pelvic absc	Drainage of Abs	January 2013	04	
59400	Routine obstetric care i	Obstetrical Care	October 2009	15	ACOG, AAFP
59409	Vaginal delivery only (w	Obstetrical Care	October 2009	15	ACOG, AAFP
59410	Vaginal delivery only (w	Obstetrical Care	October 2009	15	ACOG, AAFP
59412	External cephalic versio	Obstetrical Care	October 2009	15	ACOG, AAFP
59414	Delivery of placenta (se	Obstetrical Care	October 2009	15	ACOG, AAFP
59425	Antepartum care only;	Obstetrical Care	October 2009	15	ACOG, AAFP
59426	Antepartum care only;	Obstetrical Care	October 2009	15	ACOG, AAFP
59430	Postpartum care only (s	Obstetrical Care	October 2009	15	ACOG, AAFP
59510	Routine obstetric care i	Obstetrical Care	October 2009	15	ACOG, AAFP
59514	Cesarean delivery only;	Obstetrical Care	October 2009	15	ACOG, AAFP
59515	Cesarean delivery only;	Obstetrical Care	October 2009	15	ACOG, AAFP
59610	Routine obstetric care i	Obstetrical Care	October 2009	15	ACOG, AAFP
59612	Vaginal delivery only, a	Obstetrical Care	October 2009	15	ACOG, AAFP
59614	Vaginal delivery only, a	Obstetrical Care	October 2009	15	ACOG, AAFP
59618	Routine obstetric care i	Obstetrical Care	October 2009	15	ACOG, AAFP
59620	Cesarean delivery only,	Obstetrical Care	October 2009	15	ACOG, AAFP
59622	Cesarean delivery only,	Obstetrical Care	October 2009	15	ACOG, AAFP
60220	Total thyroid lobectom	Total Thyroid Lo	April 2008	46	ACS, AAO-HNS
60225	Total thyroid lobectom	Total Thyroid Lo	April 2008	46	ACS, AAO-HNS
60520	Thymectomy, partial or	RAW Review	January 2013	34	
60521	Thymectomy, partial or	RAW Review	January 2013	34	
60522	Thymectomy, partial or	RAW Review	January 2013	34	
61055	Cisternal or lateral cerv	Myelography	April 2014	17	
61781	Stereotactic computer-	Stereotactic Co	February 2010	13	NASS, AANS/CN

61782	Stereotactic computer-	Stereotactic Co	February 2010	13			NASS, AANS/CN
61783	Stereotactic computer-	Stereotactic Co	February 2010	13			NASS, AANS/CN
61793	Deleted from CPT	Stereotactic Ra	October 2008	26			AANS
61795	Deleted from CPT	Stereotactic Ra	February 2009	38			NASS, AAO-HNS
61796	Stereotactic radiosurge	Stereotactic Ra	February 2009	38			
61797	Stereotactic radiosurge	Stereotactic Ra	February 2009	38			
61798	Stereotactic radiosurge	Stereotactic Ra	February 2009	38			
61799	Stereotactic radiosurge	Stereotactic Ra	February 2009	38			
61800	Application of stereota	Stereotactic Ra	April 2008	16			
61885	Insertion or replacemer	Vagal Nerve Sti	February 2010	14			AANS/CNS
62263	Percutaneous lysis of e	Epidual Lysis	October 2010	66			AAPM, AANS/CI
62270	Spinal puncture, lumba	Lumbar Punctu	January 2019	09			ACR, ASNR, SIR
62272	Spinal puncture, therap	Lumbar Punctu	January 2019	09			
62281	Injection/infusion of ne	Injection of Ne	September 200	16			ASA
62284	Injection procedure for	Myelography	April 2014	17			ACR, ASNR
62287	Decompression proced	Percutaneous D	September 200	16			ASA
62290	Injection procedure for	Injection for dis	April 2010	45			ASA, AAPM, AA
62302	Myelography via lumba	Myelography	April 2014	17			ACR, ASNR
62303	Myelography via lumba	Myelography	April 2014	17			ACR, ASNR
62304	Myelography via lumba	Myelography	April 2014	17			ACR, ASNR
62305	Myelography via lumba	Myelography	April 2014	17			ACR, ASNR
62310	Injection(s), of diagnost	Epidural Injectic	October 2015	10		RUC	AAPM, AAPMR,
62311	Injection(s), of diagnost	Epidural Injectic	October 2015	10		RUC	AAPM, AAPMR,
62318	Injection(s), including ir	Epidural Injectic	October 2015	10		RUC	AAPM, AAPMR,
62319	Injection(s), including ir	Epidural Injectic	October 2015	10		RUC	AAPM, AAPMR,
62320	Injection(s), of diagnost	Epidural Injectic	October 2015	10		RUC	AANS, AANEM,
62321	Injection(s), of diagnost	Epidural Injectic	October 2015	10		RUC	AANS, AANEM,
62322	Injection(s), of diagnost	Epidural Injectic	October 2015	10		RUC	AANS, AANEM,
62323	Injection(s), of diagnost	Epidural Injectic	October 2015	10		RUC	AANS, AANEM,
62324	Injection(s), including ir	Epidural Injectic	October 2015	10		RUC	AANS, AANEM,
62325	Injection(s), including ir	Epidural Injectic	October 2015	10		RUC	AANS, AANEM,
62326	Injection(s), including ir	Epidural Injectic	October 2015	10		RUC	AANS, AANEM,
62327	Injection(s), including ir	Epidural Injectic	October 2015	10		RUC	AANS, AANEM,
62328	Spinal puncture, lumba	Lumbar Punctu	January 2019	09			
62329	Spinal puncture, therap	Lumbar Punctu	January 2019	09			
62350	Implantation, revision c	Intrathecal Epid	October 2010	67			AAPM, AANS/CI
62355	Removal of previously i	Intrathecal Epid	October 2010	67			AAPM, AANS/CI
62360	Implantation or replace	Intrathecal Epid	October 2010	67			AAPMR, ASA, N
62361	Implantation or replace	Intrathecal Epid	October 2010	67			AAPM, AANS/CI
62362	Implantation or replace	Intrathecal Epid	October 2010	67			AAPM, AANS/CI
62365	Removal of subcutaneo	Intrathecal Epid	October 2010	67			AAPMR, ASA, N
62367	Electronic analysis of pr	Electronic Anal	April 2018	14			AAPM, AAPMR,
62368	Electronic analysis of pr	Electronic Anal	April 2018	14			AAPM, AAPMR,
62369	Electronic analysis of pr	Electronic Anal	April 2018	14			AAPM, AAPMR,
62370	Electronic analysis of pr	Electronic Anal	April 2018	14			AAPM, AAPMR,
63030	Laminotomy (hemilami	RAW	January 2021	29	October 2021	RUC	AANS, AAOS, NA
63042	Laminotomy (hemilami	RAW	September 201	21			AANS, AAOS, NA

63045	Laminectomy, facetect	Laminectomy	September 201	16		RUC	Review work and di
63046	Laminectomy, facetect	Laminectomy	September 201	16		RUC	Review work and di
63047	Laminectomy, facetect	Laminectomy	January 2013	24			NASS, AANS
63048	Laminectomy, facetect	Laminectomy	January 2013	24			NASS, AANS
63056	Transpedicular approac	RAW	October 2015	21		RAW	NASS, AANS
63075	Discectomy, anterior, w	Arthrodesis Incl	February 2010	5			NASS, AANS/CN
63076	Discectomy, anterior, w	Arthrodesis Incl	February 2010	5			NASS, AANS/CN
63090	Vertebral corpectomy (	Vertebral Corpe	January 2017	30	October 2022	RAW	AAOS, AANS
63620	Stereotactic radiosurge	Stereotactic Ra	February 2009	38			
63621	Stereotactic radiosurge	Stereotactic Ra	February 2009	38			
63650	Percutaneous implanta	Percutaneous ir	October 2020	24			AAPM, AANS/CI
63655	Laminectomy for impla	Neurostimulato	April 2009	17			NASS, AANS
63660	Deleted from CPT	Neurostimulato	April 2009	17			AAPM, AANS/CI
63661	Removal of spinal neur	Neurostimulato	April 2009	17			ISIS, NASS, AAN
63662	Removal of spinal neur	Neurostimulato	April 2009	17			ISIS, NASS, AAN
63663	Revision including repla	Neurostimulato	April 2009	17			ISIS, NASS, AAN
63664	Revision including repla	Neurostimulato	April 2009	17			ISIS, NASS, AAN
63685	Insertion or replacemer	Neurostimulato	January 2021	29	January 2024	RAW	AAPM, AANS/CI
63688	Revision or removal of i	Neurostimulato	February 2008	I			AAPM, AANS/CI
64405	Injection(s), anesthetic	Injection - Grea	April 2017	17			AAN, AAPM, AA
64412	Injection, anesthetic ag	Anesthetic Injec	April 2014	36			AAN, ASA, AAPM
64415	Injection(s), anesthetic	agent(s) and/or	October 2018	09	October 2021	RUC	AAPM, ASA
64416	Injection(s), anesthetic	Anesthetic Ager	October 2018	09	October 2021	RUC	ASA
64417	Injection(s), anesthetic	Somatic Nerve I	October 2018	09	October 2021	RUC	ASA
64418	Injection(s), anesthetic	Injection, Anest	April 2016	28			AAPM, AAPMR,
64445	Injection(s), anesthetic	RAW	October 2017	19			AAPM, ASA
64446	Injection(s), anesthetic	Anesthetic Ager	October 2018	09	October 2021	RUC	ASA
64447	Injection(s), anesthetic	agent(s) and/or	October 2018	09	October 2021	RUC	AAPM, ASA
64448	Injection(s), anesthetic	Anesthetic Ager	October 2018	09	October 2021	RUC	ASA
64449	Injection(s), anesthetic	Anesthetic Ager	April 2008	19			ASA
64450	Injection(s), anesthetic	Somatic Nerve I	October 2018	09			ASA, AAPM, API
64455	Injection(s), anesthetic	Injection – Digit	April 2017	18			AAOS, AOFAS, A
64461	Paravertebral block (PV	Paravertebral B	April 2015	10			ASA
64462	Paravertebral block (PV	Paravertebral B	April 2015	10			ASA
64463	Paravertebral block (PV	Paravertebral B	April 2015	10			ASA
64470	Deleted from CPT	Injection Anesth	April 2008	57			ASA, NASS, AAP
64472	Deleted from CPT	Injection Anesth	April 2008	57			ASA, NASS, AAP
64475	Deleted from CPT	Injection Anesth	April 2008	57			ASA, NASS, AAP
64476	Deleted from CPT	Injection Anesth	April 2008	57			ASA, NASS, AAP
64479	Injection(s), anesthetic	Injection Anesth	October 2009	05			AAPM, ISIS, ASA
64480	Injection(s), anesthetic	Injection Anesth	October 2009	05			AAPM, ISIS, ASA
64483	Injection(s), anesthetic	Injection of Ane	October 2009	05			AAPM, ISIS, ASA
64484	Injection(s), anesthetic	Injection of Ane	October 2009	05			AAPM, ISIS, ASA
64490	Injection(s), diagnostic	Facet Joint Injec	April 2009	18			ASA, NASS, ASN
64491	Injection(s), diagnostic	Facet Joint Injec	April 2009	18			ASA, NASS, ASN
64492	Injection(s), diagnostic	Facet Joint Injec	April 2009	18			ASA, NASS, ASN
64493	Injection(s), diagnostic	Facet Joint Injec	April 2009	18			ASA, NASS, ASN

64494	Injection(s), diagnostic	Facet Joint Injec	April 2009	18		ASA, NASS, ASN
64495	Injection(s), diagnostic	Facet Joint Injec	April 2009	18		ASA, NASS, ASN
64510	Injection, anesthetic ag	Fluroscopy	April 2009	27		ASA, ISIS, AAPM
64520	Injection, anesthetic ag	Fluroscopy	April 2009	27		ASA, ISIS, AAPM
64550	Application of surface (	Percutaneous N	January 2017	29		AANS, CNS, AOT
64553	Percutaneous implanta	Percutaneous N	January 2017	15	RUC	AANS, CNS, ASA
64555	Percutaneous implanta	Percutaneous N	January 2019	37		AANS, CNS, ASA
64561	Percutaneous implanta	Percutaneous N	October 2020	24		AANS, CNS
64565	Percutaneous implanta	Percutaneous N	January 2017	15		AANS, CNS
64566	Posterior tibial neurosti	Posterior Tibial	January 2019	37		ACOG, AUA
64568	Incision for implantatio	Vagus Nerve Sti	February 2010	14		AANS/CNS
64573	Deleted from CPT	Neurosurgical P	February 2009	28		AANS/CNS
64581	Incision for implantatio	Urological Proc	January 2016	54		AUA
64590	Insertion or replacemer	RAW	January 2018	31		ACOG, AUA
64615	Chemodenervation of muscle(s); muscl		October 2020	23		AAN, AANEM, A
64622	Destruction by neurolyt	Fluroscopy	April 2009	27		ASA, ISIS, AAPM
64623	Destruction by neurolyt	Destruction by I	April 2008	57		ASA, NASS, AAP
64626	Destruction by neurolyt	Fluroscopy	April 2009	27		ASA, ISIS, AAPM
64627	Destruction by neurolyt	Destruction by I	April 2008	57		ASA, NASS, AAP
64633	Destruction by neurolyt	Destruction by I	October 2020	17		ASA, AAPM, AA
64634	Destruction by neurolyt	Destruction by I	October 2020	17		ASA, AAPM, AA
64635	Destruction by neurolyt	Destruction by I	October 2020	17		ASA, AAPM, AA
64636	Destruction by neurolyt	Destruction by I	October 2020	17		ASA, AAPM, AA
64640	Destruction by neurolyt	Injection Treatn	September 201	25		ASAM AAPM, A
64708	Neuroplasty, major per	Neuroplasty – L	October 2010	69		AOFAS, ASSH, A
64712	Neuroplasty, major per	Neuroplasty – L	October 2009	40		AOFAS, ASSH, A
64831	Suture of digital nerve,	Neurorrhaphy –	October 2010	70		AAOS, ASPS, AS
65105	Enucleation of eye; witl	Ophthalmologic	September 200	16		AAO
65205	Removal of foreign bod	Removal of For	April 2017	19		AAO, AOA
65210	Removal of foreign bod	Removal of For	April 2017	19		AAO, AOA
65222	Removal of foreign bod	Removal of For	September 201	26		AAO, AOA (optc
65285	Repair of laceration; co	Repair of Eye W	February 2011	8		AAO
65780	Ocular surface reconstr	Ocular Reconstr	April 2015	31		AAO
65800	Paracentesis of anterio	Paracentesis of	April 2012	21		AAO
65805	Paracentesis of anterio	Paracentesis of	April 2012	21		AAO
65855	Trabeculoplasty by lase	Trabeculoplasty	April 2015	11	RUC	AAO
66170	Fistulization of sclera fo	Glaucoma Surg	April 2015	32	RUC	AAO
66172	Fistulization of sclera fo	Glaucoma Surg	April 2015	32	RUC	AAO
66174	Transluminal dilation of	Dilation of Aqu	January 2021	15		AAO
66175	Transluminal dilation of	Dilation of Aqu	January 2021	15		AAO
66179	Aqueous shunt to extra	Aqueous Shunt	January 2014	12		AAO
66180	Aqueous shunt to extra	Aqueous Shunt	January 2020	37		AAO
66183	Insertion of anterior se	Aqueous Shunt	January 2020	37		AAO
66184	Revision of aqueous shu	Aqueous Shunt	January 2014	12		AAO
66185	Revision of aqueous shu	Aqueous Shunt	January 2020	37		AAO
66711	Ciliary body destructior	Cyclophotocoag	January 2019	11		AAO
66761	Iridotomy/iridectomy b	Iridotomy	January 2020	37		AAO

66821	Discission of secondary membranous ca	February 2011	41			AAO
66982	Extracapsular cataract r	Cataract Remov	January 2021	16		AAO
66983	Intracapsular cataract e	Cyclophotocoag	January 2019	11		
66984	Extracapsular cataract r	Cataract Remov	January 2021	16		AAO
66987	Extracapsular cataract r	Cataract Remov	January 2021	16		AAO
66988	Extracapsular cataract r	Cyclophotocoag	January 2019	11		
66989		Cataract Remov	January 2021	16		AAO
66991		Cataract Remov	January 2021	16		AAO
67028	Intravitreal injection of	Treatment of Re	April 2019	14		AAO, ASRS
67036	Vitrectomy, mechanica	Vitrectomy	October 2013	11		AAO
67038	Deleted from CPT	Ophthalmologic	September 200	16		AAO
67039	Vitrectomy, mechanica	Vitrectomy	October 2013	11		AAO
67040	Vitrectomy, mechanica	Vitrectomy	October 2013	11		AAO
67041	Vitrectomy, mechanica	Vitrectomy	October 2013	11		AAO
67042	Vitrectomy, mechanica	Vitrectomy	October 2013	11		AAO
67043	Vitrectomy, mechanica	Vitrectomy	October 2013	11		AAO
67101	Repair of retinal detach	Retinal Detachn	October 2015	11	RUC	AAO, ASRS
67105	Repair of retinal detach	Retinal Detachn	October 2015	11	RUC	AAO, ASRS
67107	Repair of retinal detach	Retinal Detachn	April 2015	12		AAO
67108	Repair of retinal detach	Retinal Detachn	April 2015	12	RUC	AAO
67110	Repair of retinal detach	Retinal Detachn	April 2015	12		AAO
67112	Repair of retinal detach	Retinal Detachn	April 2015	12		AAO
67113	Repair of complex retin	Retinal Detachn	April 2015	12	RUC	AAO
67141	Prophylaxis of retinal d	Retinal Detachn	October 2020	08		AAO, ASRS
67145	Prophylaxis of retinal d	Retinal Detachn	October 2020	08		AAO, ASRS
67210	Destruction of localized	Treatment of Re	October 2010	13		AAO
67220	Destruction of localized	Treatment of Re	October 2010	13		AAO
67225	Destruction of localized	Photodynamic T	February 2008	P		AAO
67228	Treatment of extensive	Treatment of Re	October 2009	40		AAO
67255	Scleral reinforcement (s	Aqueous Shunt	January 2014	12		AAO
67311	Strabismus surgery, rec	Strabismus Surg	October 2020	18		AAO, AAP
67312	Strabismus surgery, rec	Strabismus Surg	October 2020	18		AAO, AAP
67314	Strabismus surgery, rec	Strabismus Surg	October 2020	18		AAO, AAP
67316	Strabismus surgery, rec	Strabismus Surg	October 2020	18		AAO, AAP
67318	Strabismus surgery, any	Strabismus Surg	October 2020	18		AAO, AAP
67320	Transposition procedur	Strabismus Surg	October 2020	18		AAO, AAP
67331	Strabismus surgery on p	Strabismus Surg	October 2020	18		AAO, AAP
67332	Strabismus surgery on p	Strabismus Surg	October 2020	18		AAO, AAP
67334	Strabismus surgery by p	Strabismus Surg	October 2020	18		AAO, AAP
67335	Placement of adjustable	Strabismus Surg	October 2020	18		AAO, AAP
67340	Strabismus surgery invc	Strabismus Surg	October 2020	18		AAO, AAP
67500	Retrobulbar injection; r	Injection – Eye	October 2017	11		AAO, ASRS
67505	Retrobulbar injection; a	Injection – Eye	October 2017	11		AAO, ASRS
67515	Injection of medication	Injection – Eye	October 2017	11		AAO, ASRS
67820	Correction of trichiasis;	Correction of Tr	April 2016	29		AOA, AOA (optc
67914	Repair of ectropion; sut	Repair of Eyelid	April 2013	24		AAO
67915	Repair of ectropion; the	Repair of Eyelid	April 2013	24		AAO

67916	Repair of ectropion; ex(	Repair of Eyelid	April 2013	24	AAO
67917	Repair of ectropion; ext	Repair of Eyelid	April 2013	24	AAO
67921	Repair of entropion; su	Repair of Eyelid	April 2013	24	AAO
67922	Repair of entropion; th(	Repair of Eyelid	April 2013	24	AAO
67923	Repair of entropion; ex(	Repair of Eyelid	April 2013	24	AAO
67924	Repair of entropion; ex	Repair of Eyelid	April 2013	24	AAO
68040	Expression of conjuncti	Treatment of E\	September 201	51	AAO
68200	Subconjunctival injectic	Subconjunctival	October 2013	18	AAO
68801	Dilation of lacrimal pun	Dilation and Prc	January 2015	23	AAO, AOA (optc
68810	Probing of nasolacrimal	Dilation and Prc	January 2015	23	AAO, AOA (optc
68811	Probing of nasolacrimal duct, with or w		January 2015	23	AAO, AOA (optc
68815	Probing of nasolacrimal	Dilation and Prc	January 2015	23	AAO, AOA (optc
68816	Probing of nasolacrimal duct, with or w		January 2015	23	AAO, AOA (optc
69100	Biopsy external ear	Biopsy of Ear	April 2009	28	AAD
69200	Removal foreign body f	Removal of For(	September 201	29	AAO-HNS
69210	Removal impacted ceru	Removal of Cer	January 2015	29	AAFP, AAO-HNS
69400	Eustachian tube inflatio	Eustachian Tub(	October 2013	18	AAO-HNS
69401	Eustachian tube inflatio	Eustachian Tub(	October 2013	18	AAO-HNS
69405	Eustachian tube cathet(	Eustachian Tub(	October 2013	18	AAO-HNS
69433	Tympanostomy (requiri	Tympanostomy	September 201	30	AAO-HNS
69801	Labyrinthotomy, with p	Labyrinthotomy	October 2015	21	AAO-HNS
69802	Labyrinthotomy, with p	Labryinthotomy	April 2010	16	AAO-HNS
69930	Cochlear device implan	Cochlear Device	February 2008	M	AAO-HNS
70030	Radiologic examination	X-Ray of Eye	January 2020	28	
70100	Radiologic examination	RAW	October 2013	18	
70210	Radiologic examination	X-Ray Exam - Si	January 2019	24	AAFP, ACP, ACR
70220	Radiologic examination	X-Ray Exam - Si	January 2019	24	AAFP, ACP, ACR
70250	Radiologic examination	X-Ray Exam – Sl	January 2019	25	ACR, ASNR
70260	Radiologic examination	X-Ray Exam – Sl	January 2019	25	ACR, ASNR
70310	Radiologic examination	RAW	October 2013	18	
70360	Radiologic examination	X-Ray Exam – N	January 2019	26	AAFP, ACP, ACR
70371	Complex dynamic phar	Laryngography	January 2019	37	ACR, AAFP
70373	Laryngography, contras	Laryngography	October 2012		ACR, AAFP
70450	Computed tomography	CT Head/Brain	April 2019	15	ACR, ASNR
70460	Computed tomography	CT Head/Brain	April 2019	15	ACR, ASNR
70470	Computed tomography	CT Head/Brain	April 2019	15	ACR, ASNR
70480	Computed tomography	CT – Orbit/Ear/I	October 2018	16	ACR, ASNR
70481	Computed tomography	CT – Orbit/Ear/I	October 2018	16	ACR, ASNR
70482	Computed tomography	CT – Orbit/Ear/I	October 2018	16	ACR, ASNR
70486	Computed tomography	CT – Maxillofaci	April 2014	41	ACR, ASNR
70487	Computed tomography	CT – Maxillofaci	April 2014	41	ACR, ASNR
70488	Computed tomography	CT – Maxillofaci	April 2014	41	ACR, ASNR
70490	Computed tomography	CT Soft Tissue N	January 2017	21	ACR, ASNR
70491	Computed tomography	CT Soft Tissue N	January 2017	21	ACR, ASNR
70492	Computed tomography	CT Soft Tissue N	January 2017	21	ACR, ASNR
70496	Computed tomographic	CT Angiography	January 2019	37	ACR, ASNR
70498	Computed tomographic	CT Angiography	January 2019	37	ACR, ASNR

70540	Magnetic resonance (e	MRI Face and N	January 2016	39	ACR, ASNR
70542	Magnetic resonance (e	MRI Face and N	January 2016	39	ACR, ASNR
70543	Magnetic resonance (e	MRI Face and N	January 2016	39	ACR, ASNR
70544	Magnetic resonance an	Magnetic Resor	October 2016	18	RUC ACR, ASNR
70545	Magnetic resonance an	Magnetic Resor	October 2016	18	RUC ACR, ASNR
70546	Magnetic resonance an	Magnetic Resor	October 2016	18	RUC ACR, ASNR
70547	Magnetic resonance an	Magnetic Resor	October 2016	19	RUC ACR, ASNR
70548	Magnetic resonance an	Magnetic Resor	October 2016	19	RUC ACR, ASNR
70549	Magnetic resonance an	Magnetic Resor	October 2016	19	RUC ACR, ASNR
70551	Magnetic resonance (e	MRI-Brain	January 2013	26	ACR, ASNR
70552	Magnetic resonance (e	MRI-Brain	January 2013	26	ACR, ASNR
70553	Magnetic resonance (e	MRI-Brain	January 2013	26	ACR, ASNR
71010	Radiologic examination	Chest X-Rays	April 2016	07	ACR
71015	Radiologic examination	Chest X-Rays	April 2016	07	ACR
71020	Radiologic examination	Chest X-Rays	April 2016	07	ACR
71021	Radiologic examination	Chest X-Rays	April 2016	07	ACR
71022	Radiologic examination	Chest X-Rays	April 2016	07	ACR
71023	Radiologic examination	Chest X-Ray	April 2016	07	ACR
71030	Radiologic examination	Chest X-Rays	April 2016	07	ACR
71034	Radiologic examination	Chest X-Rays	April 2016	07	ACR
71035	Radiologic examination	Chest X-Rays	April 2016	07	ACR
71045	Radiologic examination	Chest X-Ray	April 2016	07	ACR
71046	Radiologic examination	Chest X-Ray	April 2016	07	ACR
71047	Radiologic examination	Chest X-Ray	April 2016	07	ACR
71048	Radiologic examination	Chest X-Ray	April 2016	07	ACR
71090	Insertion pacemaker, fl	Insertion/Remo	April 2011	10	ACC
71100	Radiologic examination	X-Ray of Ribs	April 2016	30	ACR
71101	Radiologic examination	X-Ray of Ribs	April 2016	30	ACR
71110	Radiologic examination	X-Ray of Ribs	April 2016	30	ACR
71111	Radiologic examination	X-Ray of Ribs	April 2016	30	ACR
71250	Computed tomography	Screening CT of	October 2019	07	ACR
71260	Computed tomography	Screening CT of	October 2019	07	ACR
71270	Computed tomography	Screening CT of	October 2019	07	ACR
71271	Computed tomography	Screening CT of	October 2019	07	
71275	Computed tomographic	CT Angiography	January 2014	27	ACR, SIR
72020	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72040	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72050	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72052	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72070	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72072	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72074	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72080	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72100	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72110	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72114	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN
72120	Radiologic examination	X-Ray Spine	January 2019	27	AAOS, ACR, ASN

72125	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72126	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72127	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72128	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72129	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72130	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72131	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72132	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72133	Computed tomography	CT Spine	April 2018	18		ACR, ASNR
72141	Magnetic resonance (e	MRI Neck and L	April 2013	25		ACR
72142	Magnetic resonance (e	MRI Neck and L	April 2013	25		ACR
72146	Magnetic resonance (e	MRI Neck and L	April 2013	25		ACR
72147	Magnetic resonance (e	MRI Neck and L	April 2013	25		ACR
72148	Magnetic resonance (e	MRI Neck and L	April 2013	25		AAOS, AUR, ACF
72149	Magnetic resonance (e	MRI Neck and L	April 2013	25		
72156	Magnetic resonance (e	MRI Neck and L	April 2013	25		
72157	Magnetic resonance (e	MRI Neck and L	April 2013	25		
72158	Magnetic resonance (e	MRI Neck and L	April 2013	25		
72170	Radiologic examination	X-Ray Exam – P	January 2019	28		AAOS, ACR
72190	Radiologic examination	X-Ray Exam – P	January 2019	28		AAOS, ACR
72191	Computed tomographic	CT Angiography	October 2013	12		ACR, SIR
72192	Computed tomography	CT Pelvis	October 2008	26		ACR
72193	Computed tomography	CT Pelvis	October 2008	26		ACR
72194	Computed tomography	CT Abdomen an	April 2014	44		ACR
72195	Magnetic resonance (e	MRI Pelvis	October 2016	21	RUC	ACR
72196	Magnetic resonance (e	MRI Pelvis	October 2016	21	RUC	ACR
72197	Magnetic resonance (e	MRI Pelvis	October 2016	21	RUC	ACR
72200	Radiologic examination	X-Ray Sacrum	January 2019	29		AAOS, ACR
72202	Radiologic examination	X-Ray Sacrum	January 2019	29		AAOS, ACR
72220	Radiologic examination	X-Ray Sacrum	January 2019	29		AAOS, ACR
72240	Myelography, cervical,	Myelography	April 2014	17		ACR, ASNR
72255	Myelography, thoracic,	Myelography	April 2014	17		ACR, ASNR
72265	Myelography, lumbosa	Myelography	April 2014	17		ACR, ASNR
72270	Myelography, 2 or mor	Myelography	April 2014	17		ACR, ASNR
72275	Epidurography, radiolo	Epidurography	January 2020	37		ASA, AAPM, AA
72291	Radiological supervisior	Percutaneous V	April 2014	06		
72292	Radiological supervisior	Percutaneous V	April 2014	06		
73000	Radiologic examination	X-Ray – Clavicle	October 2018	17		ACR, AAOS
73010	Radiologic examination	X-Ray – Clavicle	October 2018	17		ACR, AAOS
73020	Radiologic examination	X-Ray – Clavicle	October 2018	17		ACR, AAOS
73030	Radiologic examination	X-Ray – Clavicle	October 2018	17		ACR, AAOS
73050	Radiologic examination	X-Ray – Clavicle	October 2018	17		ACR, AAOS
73060	Radiologic examination	X-Ray Exams	September 201	17		AAOS, ACR
73070	Radiologic examination	X-Ray Elbow/Fo	January 2019	30		AAOS, ACR, ASS
73080	Radiologic examination	X-Ray Elbow/Fo	January 2019	30		AAOS, ACR, ASS
73090	Radiologic examination	X-Ray Elbow/Fo	January 2019	30		AAOS, ACR, ASS
73100	Radiologic examination	X-Ray Wrist	April 2016	32		ACR

73110	Radiologic examination	X-Ray Wrist	April 2016	32		ACR
73120	Radiologic examination	X-Ray of Hand/I	April 2016	33		ACR
73130	Radiologic examination	X-Ray of Hand/I	April 2016	33		ACR
73140	Radiologic examination	X-Ray of Hand/I	April 2016	33		ACR
73200	Computed tomography	CT Upper Extrer	October 2009	23		ACR
73201	Computed tomography	CT Upper Extrer	October 2009	40		ACR
73202	Computed tomography	CT Upper Extrer	October 2009	40		ACR
73206	Computed tomographic	CT Angiography	October 2013	12		ACR, SIR
73218	Magnetic resonance (e	MRI	October 2013	18		ACR
73221	Magnetic resonance (e	MRI	January 2012	20		ACR
73500	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73501	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73502	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73503	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73510	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73520	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73521	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73522	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73523	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73540	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73542	Radiological examinatic	Sacroiliac Joint ,	April 2010	45		ASA, AAPM, AA
73550	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73551	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73552	Radiologic examination	Radiologic Exan	April 2015	14		AAOS, ACR
73560	Radiologic examination	X-Ray Exams	September 201	17		AAOS, ACR
73562	Radiologic examination	X-Ray Exams	September 201	17		AAOS, ACR
73564	Radiologic examination	X-Ray Exams	September 201	17		AAOS, ACR
73565	Radiologic examination	X-Ray Exams	September 201	17		AAOS, ACR
73580	Radiologic examination	Contrast X-Ray	October 2020	23	October 2021 RUC	AAOS
73590	Radiologic examination	X-Ray Exams	September 201	17		AAOS, ACR
73600	Radiologic examination	X-Ray Exams	September 201	17		AAOS, ACR, APM
73610	Radiologic examination	Radiologic Exan	October 2009	24		ACR, AAOS, APM
73620	Radiologic examination	X-Ray Exam of F	April 2011	27		ACR, AAOS, APM
73630	Radiologic examination	Radiologic Exan	October 2009	24		ACR, AAOS, APM
73650	Radiologic examination	X-Ray Heel	January 2019	31		AAOS, ACR, APM
73660	Radiologic examination	X-Ray Toe	January 2019	32		AAOS, ACR, APM
73700	Computed tomography	CT Lower Extrer	April 2018	21		ACR
73701	Computed tomography	CT Lower Extrer	April 2018	21		ACR
73702	Computed tomography	CT Lower Extrer	April 2018	21		ACR
73706	Computed tomographic	CT Angiography	October 2013	12		ACR, SIR
73718	Magnetic resonance (e	MRI Lower Extr	October 2016	20	RUC	ACR
73719	Magnetic resonance (e	MRI Lower Extr	October 2016	20	RUC	ACR
73720	Magnetic resonance (e	MRI Lower Extr	October 2016	20	RUC	ACR
73721	Magnetic resonance (e	MRI of Lower E	January 2012	20		ACR
74000	Radiologic examination	Abdominal X-Ra	April 2016	08		ACR
74010	Radiologic examination	Abdominal X-Ra	April 2016	08		ACR
74018	Radiologic examination	Abdominal X-Ra	April 2016	08		ACR

74019	Radiologic examination	Abdominal X-Ra	April 2016	08		ACR
74020	Radiologic examination	Abdominal X-Ra	April 2016	08		ACR
74021	Radiologic examination	Abdominal X-Ra	April 2016	08		ACR
74022	Radiologic examination	Abdominal X-Ra	April 2016	08		ACR
74150	Computed tomography	CT Abdomen	February 2008	S		ACR
74160	Computed tomography	CT Abdomen an	April 2014	44		ACR
74170	Computed tomography	CT Abdomen	April 2012	34		ACR
74174	Computed tomographic	CT Angiography	October 2013	12		ACR, SIR
74175	Computed tomographic	CT Angiography	October 2013	12		ACR, SIR
74176	Computed tomography	CT Abdomen/C	February 2010	16		ACR
74177	Computed tomography	CT Abdomen an	April 2014	44		ACR
74178	Computed tomography	CT Abdomen/C	February 2010	16		ACR
74181	Magnetic resonance (e	MRI of Abdome	October 2016	21	RUC	ACR
74182	Magnetic resonance (e	MRI of Abdome	October 2016	21	RUC	ACR
74183	Magnetic resonance (e	MRI of Abdome	October 2016	21	RUC	ACR
74210	Radiologic examination	X-Ray Exam – U	January 2019	12		ACR
74220	Radiologic examination	X-Ray Exam – U	January 2019	12		ACR
74221	Radiologic examination	X-Ray Exam – U	January 2019	12		
74230	Radiologic examination	X-Ray Esophagu	April 2017	25		ACR
74240	Radiologic examination	X-Ray Exam – U	January 2019	12		ACR
74241	Radiologic examination	X-Ray Exam – U	January 2019	12		ACR
74245	Radiologic examination	X-Ray Exam – U	January 2019	12		ACR
74246	Radiologic examination	X-Ray Exam – U	January 2019	12		ACR
74247	Radiological examinatic	X-Ray Exam – U	January 2019	12		ACR
74248	Radiologic small intesti	X-Ray Exam – U	January 2019	12		
74249	Radiological examinatic	X-Ray Exam – U	January 2019	12		ACR
74250	Radiologic examination	Lower Gastroin	October 2018	11		ACR
74251	Radiologic examination	Lower Gastroin	October 2018	11		ACR
74260	Duodenography, hypot	X-Ray Exam – Si	October 2018	11		ACR
74270	Radiologic examination	Lower Gastroin	October 2018	11		ACR
74280	Radiologic examination	Lower Gastroin	October 2018	11		ACR
74300	Cholangiography and/o	X-Rays at Surge	April 2019	19		ACR, SAGES
74301	Cholangiography and/o	X-Rays at Surge	October 2020	19		ACR, ACS, SAGE
74305	Deleted from CPT	Percutaneous B	October 2015	06	RUC	ACR, SIR
74320	Cholangiography, percu	Percutaneous B	October 2015	06	RUC	ACR, SIR
74327	Postoperative biliary du	Percutaneous B	October 2015	06	RUC	ACR, SIR
74328	Endoscopic catheterizat	X-Rays at Surge	April 2019	19		ACR, SAGES
74329	Endoscopic catheterizat	X-Rays at Surge	April 2019	19		ACR, SAGES
74330	Combined endoscopic c	X-Rays at Surge	April 2019	19		ACR, SAGES
74400	Urography (pyelograph	Contrast X-Ray	September 201	31		ACR
74420	Urography, retrograde,	X-Ray Urinary T	April 2017	26		ACR, AUA
74425	Urography, antegrade,	Urography	October 2018	18		ACR, AUA, SIR
74475	Introduction of intracat	Genitourinary C	January 2015	09		ACR, SIR
74480	Introduction of uretera	Genitourinary C	January 2015	09		ACR, SIR
74485	Dilation of ureter(s) or	Dilation of Urin	January 2018	12		
75561	Cardiac magnetic resonance imaging fo		January 2021	29		
75572	Computed tomography, heart, with cor		January 2021	29		

75574	Computed tomographic angiography, h		January 2021	29			ACR, SIR, ACC
75625	Aortography, abdomina	Abdominal Aort	October 2018	19			ACC, SCAI, SIR, S
75630	Aortography, abdomina	Abdominal Aort	October 2018	19			ACC, SCAI, SIR, S
75635	Computed tomographic	CT Angiography	April 2016	34			ACR
75650	Angiography, carotid, c	Carotid Angiogr	April 2010	45			ACC, ACR, ASNR
75671	Angiography, carotid, c	Carotid Angiogr	April 2010	45			AANS/CNS, ACC
75680	Angiography, carotid, c	Carotid Angiogr	April 2010	45			AANS/CNS, ACC
75710	Angiography, extremity	Angiography of	January 2021	29	January 2024	RAW	ACR, ACC, RPA,
75716	Angiography, extremity	Angiography of	October 2016	22		RUC	ACR, ACC, RPA,
75722	Angiography, renal, uni	Renal Angiogra	April 2010	45			ACC, ACR, ASNR
75724	Angiography, renal, bila	Renal Angiogra	April 2010	45			ACC, ACR, ASNR
75726	Angiography, visceral, s	Angiography	October 2018	20			SCAI, SIR, SVS
75774	Angiography, selective,	Angiography	October 2018	20			SCAI, SIR, SVS
75790	Deleted from CPT	Arteriovenous S	April 2009	9			SVS, SIR, ACR
75791	Angiography, arteriover	Dialysis Circuit -	January 2016	14			ACR, RPA, SIR, S
75820	Venography, extremity,	Venography	January 2020	29			
75822	Venography, extremity,	Venography	January 2020	29			
75885	Percutaneous transhep	Interventional F	February 2009	21			ACR, SIR
75887	Percutaneous transhep	Interventional F	February 2009	21			ACR, SIR
75894	Transcatheter therapy,	Transcatheter P	January 2021	29			ACC, ACR, SIR, S
75896	Transcatheter therapy,	Intracranial End	April 2015	09			AANS/CNS, ACR
75898	Angiography through e	Intracranial End	January 2019	37			AANS/CNS, ACR
75940	Percutaneous placemer	Major Vein Revi	April 2010	45			ACR, SIR, SVS
75945	Intravascular ultrasoun	Intravascular Ul	January 2015	07			ACC,SCAI, SIR, S
75946	Intravascular ultrasoun	Intravascular Ul	January 2015	07			ACC,SCAI, SIR, S
75952	Endovascular repair of i	Endovascular R	January 2017	10			SVS, SIR, STS, A/
75953	Placement of proximal	Endovascular R	January 2017	10			SVS, SIR, STS, A/
75954	Endovascular repair of i	Endovascular R	January 2017	10			SVS, SIR, STS, A/
75960	Transcatheter introduct	RAW	October 2012	27			ACC, ACR, SIR, S
75961	Transcatheter retrieval,	Transcatheter P	April 2010	45			ACC, ACR, SIR, S
75962	Transluminal balloon ar	Open and Percu	January 2016	15			ACR, SIR, SVS
75964	Transluminal balloon ar	Open and Percu	January 2016	15			ACR, SIR, SVS
75966	Transluminal balloon ar	Open and Percu	January 2016	15			ACR, SIR, SVS
75968	Transluminal balloon ar	Open and Percu	January 2016	15			ACR, SIR, SVS
75978	Transluminal balloon ar	Open and Percu	January 2016	15			ACR, SIR, SVS
75980	Percutaneous transhep	Percutaneous B	October 2015	06		RUC	ACR, SIR
75982	Percutaneous placemer	Percutaneous B	October 2015	06		RUC	ACR, SIR
75984	Change of percutaneou	Introduction of	April 2019	17			ACR, SIR
75992	Deleted from CPT	Transluminal Ar	April 2008	57			SIR, ACR, SVS
75993	Deleted from CPT	Transluminal Ar	April 2008	57			SIR, ACR, SVS
75994	Revised to Category III	Transluminal Ar	April 2008	57			SIR, ACR, SVS
75995	Revised to Category III	Transluminal Ar	April 2008	57			SIR, ACR, SVS
75996	Revised to Category III	Transluminal Ar	April 2008	57			SIR, ACR, SVS
76000	Fluoroscopy (separate p	Fluoroscopy	April 2017	27			ACR, APMA
76001	Fluoroscopy, physician	Fluoroscopy	April 2017	27			ACR
76098	Radiological examinatic	X-Ray Exam Spe	October 2018	21			ACR
76100	Radiologic examination	Fluroscopy	April 2009	27			ACR, ISIS

76101	Radiologic examination	Fluroscopy	April 2009	27			ACR, ISIS
76102	Radiologic examination	Fluroscopy	April 2009	27			ACR, ISIS
76376	3D rendering with inter	3D Rendering	April 2018	23			ACR, ASNR
76377	3D rendering with inter	3D Rendering w	January 2020	30	October 2021	RUC	ACR, ASNR, SIR
76510	Ophthalmic ultrasound,	Opthalmic Ultra	October 2016	23		RUC	AAO, ASRS, AOA
76511	Ophthalmic ultrasound,	Opthalmic Ultra	October 2016	23		RUC	AAO, ASRS, AOA
76512	Ophthalmic ultrasound,	Opthalmic Ultra	October 2016	23		RUC	AAO, ASRS, AOA
76513	Ophthalmic ultrasound,	Ophthalmic Ulti	January 2020	17			AAO, AOA (optc
76514	Ophthalmic ultrasound,	Echo Exam of E	October 2017	12			AAO, AOA (optc
76516	Ophthalmic biometry b	Opthalmic Biom	April 2016	36			AAO, AOA (optc
76519	Ophthalmic biometry b	Opthalmic Biom	April 2016	36			AAO, AOA (optc
76536	Ultrasound, soft tissues	Soft Tissue Ultra	April 2009	29			ACR, ASNR, TES
76604	Ultrasound, chest (inclu	Ultrasound Exa	April 2018	24			ACR
76641	Ultrasound, breast, unil	Breast Ultrasou	January 2014	13			ACR
76642	Ultrasound, breast, unil	Breast Ultrasou	January 2014	13			ACR
76645	Ultrasound, breast(s) (u	Breast Ultrasou	January 2014	13			ACR
76700	Ultrasound, abdominal,	Ultrasound	October 2013	13			ACR
76705	Ultrasound, abdominal,	Ultrasound	October 2013	13			ACR, ASBS
76706	Ultrasound, abdominal	Abdominal Aort	October 2015	12			ACR, SIR, SVS
76770	Ultrasound, retroperito	Ultrasound	October 2013	13			ACR
76775	Ultrasound, retroperito	Ultrasound	October 2013	13			ACR
76819	Fetal biophysical profile	RAW	October 2013	18			
76830	Ultrasound, transvagina	Transvaginal an	April 2012	44			ACOG, ACR, AUA
76856	Ultrasound, pelvic (non	Ultrasound	October 2013	13			ACR
76857	Ultrasound, pelvic (non	Ultrasound	October 2013	13			ACR
76870	Ultrasound, scrotum an	Ultrasound Exa	April 2017	28			ACR, AUA
76872	Ultrasound, transrectal	Transvaginal an	April 2012	44			ACOG, ACR, AUA
76880	Deleted from CPT	Lower Extremit	October 2009	26			APMA, ACR
76881	Ultrasound, complete j	Ultrasound of E	October 2019	17	October 2021	RAW	AAOS, ACR, ACR
76882	Ultrasound, limited, joi	Ultrasound of E	October 2019	17	October 2021	RAW	AAOS, ACR, ACR
76930	Ultrasonic guidance for	Pericardiocente	January 2019	04			ACC
76932	Ultrasonic guidance for	Ultrasound Gui	April 2014	34			ACC
76936	Ultrasound guided com	RAW	October 2013	18			
76937	Ultrasound guidance fo	PICC Line Proce	January 2018	09	October 2021	RAW	
76940	Ultrasound guidance fo	Ultrasound Gui	January 2015	29			ACS, ACR, SIR
76942	Ultrasonic guidance for	Ultrasound Gui	April 2014	35	October 2021	RUC	AACE, AAOS, AA
76948	Ultrasonic guidance for	Echo Guidance	January 2015	25			ACOG
76950	Ultrasonic guidance for	Ultrasound Gui	April 2014	34			
76965	Ultrasonic guidance for	Ultrasound Gui	September 201	21			NO INTERESET
76970	Ultrasound study follow	IMRT with Ultra	October 2019	17			ACS, ACR, AACE
76998	Ultrasonic guidance, intraoperative		October 2019	17	January 2022	RUC	STS, AATS, ACS,
77001	Fluoroscopic guidance f	PICC Line Proce	January 2018	09		RUC	AANS, AANEM,
77002	Fluoroscopic guidance f	Fluoroscopic Gu	October 2015	13			AANS, AANEM,
77003	Fluoroscopic guidance a	Fluoroscopic Gu	October 2015	13		RUC	AANS, AANEM,
77011	Computed tomography	IMRT with CT G	October 2010	15			ASTRO, ACRO
77012	Computed tomography	Lung Biopsy-CT	April 2019	05	April 2022		ACR, SIR
77014	Computed tomography	IMRT with CT G	October 2019	17	October 2021	RAW	ASTRO, ACR

77031	Stereotactic localizatior	Breast Biopsy	April 2013	04	
77032	Mammographic guidan	Breast Biopsy	April 2013	04	
77046	Magnetic resonance im	Breast MRI with	October 2017	06	ACR
77047	Magnetic resonance im	Breast MRI with	October 2017	06	ACR
77048	Magnetic resonance im	Breast MRI with	October 2017	06	ACR
77049	Magnetic resonance im	Breast MRI with	October 2017	06	ACR
77051	Computer-aided detect	Mammography	January 2016	20	ACR
77052	Computer-aided detect	Mammography	January 2016	20	ACR
77055	Mammography; unilate	Mammography	January 2016	20	ACR
77056	Mammography; bilater	Mammography	January 2016	20	ACR
77057	Screening mammograp	Mammography	January 2016	20	ACR
77058	Magnetic resonance im	Breast MRI with	October 2017	06	ACR
77059	Magnetic resonance im	Breast MRI with	October 2017	06	ACR
77065	Diagnostic mammograp	Mammography	January 2016	20	ACR
77066	Diagnostic mammograp	Mammography	January 2016	20	ACR
77067	Screening mammograp	Mammography	January 2016	20	ACR
77073	Bone length studies (or	X-Ray Exam - Bo	April 2018	25	AAOS, ACR
77074	Radiologic examination	X-Ray Exam - Bo	April 2018	25	ACR
77075	Radiologic examination	X-Ray Exam - Bo	April 2018	25	ACR
77076	Radiologic examination	X-Ray Exam - Bo	April 2018	25	ACR
77077	Joint survey, single viev	X-Ray Exam - Bo	April 2018	25	ACR
77079	Computed tomography	CT Bone Densit	February 2010	31	ACR, AAFP, ACP
77080	Dual-energy X-ray abso	Dual Energy X-R	October 2013	07	AACE, ACNM, A
77081	Dual-energy X-ray abso	Dual-energy X-F	January 2018	25	
77082	Dual-energy X-ray abso	Dual Energy X-R	October 2013	07	AACE, ACNM, A
77083	Radiographic absorptio	Radiographic Al	February 2010	31	ACR, ACP
77085	Dual-energy X-ray abso	Dual Energy X-R	October 2013	07	AACE, ACNM, A
77086	Vertebral fracture asse	Dual Energy X-R	October 2013	07	AACE, ACNM, A
77261	Therapeutic radiology t	Radiation Thera	April 2016	37	ASTRO
77262	Therapeutic radiology t	Radiation Thera	April 2016	37	ASTRO
77263	Therapeutic radiology t	Radiation Thera	April 2016	37	ASTRO
77280	Therapeutic radiology s	Set Radiation Th	January 2013	14	ASTRO
77285	Therapeutic radiology s	Respiratory Mo	January 2013	14	ASTRO
77290	Therapeutic radiology s	Respiratory Mo	January 2013	14	ASTRO
77293	Respiratory motion ma	Respiratory Mo	January 2013	14	ASTRO
77295	3-dimensional radiothe	Surface Radiou	January 2013	14	ASTRO
77300	Basic radiation dosimet	Surface Radiou	April 2014	20	ASTRO
77301	Intensity modulated rac	IMRT - PE Only	April 2013	28	ASTRO
77305	Teletherapy, isodose pl	Isodose Calcula	April 2014	20	ASTRO
77306	Teletherapy isodose pla	Isodose Calcula	April 2014	20	
77307	Teletherapy isodose pla	Isodose Calcula	April 2014	20	
77310	Teletherapy, isodose pl	Isodose Calcula	April 2014	20	ASTRO
77315	Teletherapy, isodose pl	Isodose Calcula	April 2014	20	ASTRO
77316	Brachytherapy isodose	Isodose Calcula	April 2014	20	
77317	Brachytherapy isodose	Isodose Calcula	April 2014	20	
77318	Brachytherapy isodose	Isodose Calcula	October 2015	21	
77326	Brachytherapy isodose	Isodose Calcula	April 2014	20	

77327	Brachytherapy isodose	Isodose Calcula	April 2014	20		ASTRO
77328	Brachytherapy isodose	Isodose Calcula	April 2014	20		
77332	Treatment devices, des	RAW	January 2016	40	RUC	ASTRO
77333	Treatment devices, des	RAW	January 2016	40	RUC	ASTRO
77334	Treatment devices, design and construc		January 2016	40	RUC	ASTRO
77336	Continuing medical phy	Continuing Mec	April 2013	31		ASTRO
77338	Multi-leaf collimator (M	IMRT - PE Only	April 2013	28		
77371	Radiation treatment de	Radiation Treat	April 2009	30		ASTRO
77372	Radiation treatment de	Radiation Treat	October 2013	18		
77373	Stereotactic body radia	Radiation Treat	October 2013	18		ACR, ASTRO, AC
77385	Intensity modulated rad	Radiation Treat	January 2014	14		ACRO, ASTRO
77386	Intensity modulated rad	Radiation Treat	January 2014	14		ACRO, ASTRO
77387	Guidance for localizatio	Radiation Treat	January 2014	14		ACRO, ASTRO
77401	Radiation treatment de	Radiation Treat	January 2020	31		
77402	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77403	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77404	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77406	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77407	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77408	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77409	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77411	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77412	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77413	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77414	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77416	Radiation treatment de	Radiation Treat	January 2014	14		ACRO, ASTRO
77418	Intensity modulated tre	Radiation Treat	January 2014	14		ACRO, ASTRO
77421	Stereoscopic X-ray guid	Radiation Treat	January 2014	14		ACRO, ASTRO
77422	High energy neutron ra	High Energy Ne	April 2015	35	RUC	AAOS, ASPS, AS
77423	High energy neutron ra	High Energy Ne	April 2015	35	RUC	AAOS, ASPS, AS
77427	Radiation treatment ma	Radiation Treat	January 2016	54		ASTRO
77435	Stereotactic body radia	RAW	January 2017	30		
77470	Special treatment proc	Special Radiatio	January 2016	41		ASTRO
77520	Proton treatment delive	Proton Beam Tr	April 2019	19		ASTRO
77522	Proton treatment delive	Proton Beam Tr	April 2019	19		ASTRO
77523	Proton treatment delive	Proton Beam Tr	April 2019	19		ASTRO
77525	Proton treatment delive	Proton Beam Tr	April 2019	19		ASTRO
77600	Hyperthermia, external	Hyperthermia -	April 2013	30		
77767	Remote afterloading hi	Surface Radion	January 2015	16		ASTRO, ACRO
77768	Remote afterloading hi	Surface Radion	January 2015	16		ASTRO, ACRO
77770	Remote afterloading hi	Surface Radion	January 2015	16		ASTRO, ACRO
77771	Remote afterloading hi	Surface Radion	January 2015	16		ASTRO, ACRO
77772	Remote afterloading hi	Surface Radion	January 2015	16		ASTRO, ACRO
77776	Interstitial radiation so	Interstitial Radi	April 2015	17		ACR, ASTRO
77777	Interstitial radiation so	Interstitial Radi	April 2015	17		ACR, ASTRO
77778	Interstitial radiation so	Interstitial Radi	October 2015	21		ACR, ASTRO
77781	Deleted from CPT	Brachytherapy	October 2008	26		ASTRO

77782	Deleted from CPT	Brachytherapy	February 2008	S	ASTRO
77784	Deleted from CPT	Brachytherapy	February 2008	S	ASTRO
77785	Remote afterloading hi	Surface Radionu	January 2015	16	ASTRO
77786	Remote afterloading hi	Surface Radionu	January 2015	16	ASTRO
77787	Remote afterloading hi	Surface Radionu	January 2015	16	ASTRO
77790	Supervision, handling, l	Interstitial Radi	October 2015	21	ACR, ASTRO, SIF
78000	Thyroid uptake; single c	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78001	Thyroid uptake; multipl	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78003	Thyroid uptake; stimula	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78006	Thyroid imaging, with u	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78007	Thyroid imaging, with u	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78010	Thyroid imaging; only	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78011	Thyroid imaging; with v	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78012	Thyroid uptake, single c	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78013	Thyroid imaging (includ	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78014	Thyroid imaging (includ	Thyroid Uptake,	April 2012	22	ACR, ACNM, SN
78070	Parathyroid planar ima	Parathyroid Ima	January 2016	54	ACR, ACNM, SN
78071	Parathyroid planar ima	Parathyroid Ima	January 2016	54	ACR, ACNM, SN
78072	Parathyroid planar ima	Parathyroid Ima	January 2016	54	ACR, ACNM, SN
78223	Hepatobiliary ductal sy	Hepatobiliary D	February 2011	12	ACR, SNM
78226	Hepatobiliary system in	Hepatobiliary Sy	February 2011	12	ACR, SNM, ACN
78227	Hepatobiliary system in	Hepatobiliary Sy	February 2011	12	ACR, SNM, ACN
78265	Gastric emptying imagi	Colon Transit In	April 2015	18	ACNM, ACR, SN
78266	Gastric emptying imagi	Colon Transit In	April 2015	18	ACNM, ACR, SN
78278	Acute gastrointestinal b	Acute GI Blood	September 201	34	ACR, SNM, ACN
78300	Bone and/or joint imag	Bone Imaging	April 2016	38	ACNM, ACR, SN
78305	Bone and/or joint imag	Bone Imaging	April 2016	38	ACNM, ACR, SN
78306	Bone and/or joint imag	Bone Imaging	April 2016	38	ACNM, ACR, SN
78429	Myocardial imaging, po	Myocardial PET	January 2019	13	ACC, ACR, ACNM
78430	Myocardial imaging, po	Myocardial PET	January 2019	13	ACC, ACR, ACNM
78431	Myocardial imaging, po	Myocardial PET	January 2019	13	ACC, ACR, ACNM
78432	Myocardial imaging, po	Myocardial PET	January 2019	13	ACC, ACR, ACNM
78433	Myocardial imaging, po	Myocardial PET	January 2019	13	ACC, ACR, ACNM
78434	Absolute quantitation c	Myocardial PET	January 2019	13	ACC, ACR, ACNM
78451	Myocardial perfusion in	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78452	Myocardial perfusion in	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78453	Myocardial perfusion in	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78454	Myocardial perfusion in	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78459	Myocardial imaging, po	Myocardial PET	January 2019	13	ACC, ACR, ACNM
78460	Deleted from CPT	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78461	Deleted from CPT	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78464	Deleted from CPT	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78465	Deleted from CPT	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78472	Cardiac blood pool ima	Cardiac Blood P	September 201	35	ACC, ACR, SNM,
78478	Deleted from CPT	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78480	Deleted from CPT	Myocardial Perf	February 2009	16	SNM, ACR, ASN
78491	Myocardial imaging, po	Myocardial PET	January 2019	13	ACC, ACR, ACNM

78492	Myocardial imaging, po	Myocardial PET	January 2019	13		ACC, ACR, ACNM
78579	Pulmonary ventilation i	Pulmonary Ima	February 2011	13		ACR, SNM
78580	Pulmonary perfusion in	Pulmonary Ima	February 2011	13		SNM, ACR
78582	Pulmonary ventilation (	Pulmonary Ima	February 2011	13		ACR, SNM
78584	Pulmonary perfusion in	Pulmonary Perf	February 2010	31		SNM, ACR
78585	Pulmonary perfusion in	Pulmonary Perf	February 2010	31		SNM, ACR
78586	Pulmonary ventilation i	Pulmonary Perf	February 2010	31		SNM, ACR
78587	Deleted from CPT	Pulmonary Perf	February 2010	31		SNM, ACR
78588	Deleted from CPT	Pulmonary Perf	February 2010	31		SNM, ACR
78591	Deleted from CPT	Pulmonary Perf	February 2010	31		SNM, ACR
78593	Deleted from CPT	Pulmonary Perf	February 2010	31		SNM, ACR
78594	Deleted from CPT	Pulmonary Perf	February 2010	31		SNM, ACR
78596	Deleted from CPT	Pulmonary Perf	February 2010	31		SNM, ACR
78597	Quantitative differentia	Pulmonary Ima	February 2011	13		ACR, SNM
78598	Quantitative differentia	Pulmonary Ima	February 2011	13		ACR, SNM
78803	Radiopharmaceutical lo	RAW	January 2019	14		ACR, ACNM, SN
78815	Positron emission tomography (PET) wi		February 2011	41		ACR, SNM
79101	Radiopharmaceutical th	Radiopharmace	February 2010	31		SNM, ACR
80500	Clinical pathology consu	Pathology Clinic	January 2021	20		CAP
80502	Clinical pathology consu	Pathology Clinic	January 2021	20		CAP
80503		Pathology Clinic	January 2021	20		CAP
80504		Pathology Clinic	January 2021	20		CAP
80505		Pathology Clinic	January 2021	20		CAP
80506		Pathology Clinic	January 2021	20		CAP
85060	Blood smear, periphera	Blood Smear Int	April 2017	30		CAP
85097	Bone marrow, smear in	Bone Marrow Ir	April 2017	31		CAP
85390	Fibrinolysins or coagulo	Fibrinolysins Sc	January 2018	26		
88104	Cytopathology, fluids, v	Cytopathology	April 2015	36		AUR, ASC, CAP
88106	Cytopathology, fluids, v	Cytopathology	April 2015	36		AUR, ASC, CAP
88107	Deleted from CPT	Cytopathology	October 2010	17		AUR, ASC, CAP
88108	Cytopathology, concent	Cytopathology (	April 2015	36	RUC	ACR, CAP
88112	Cytopathology, selectiv	Cytopathology (	April 2015	36	RUC	ACR, CAP
88120	Cytopathology, in situ h	RAW review	October 2017	19		
88121	Cytopathology, in situ h	RAW review	October 2017	19		
88141	Cytopathology, cervical	Cytopathology (	April 2018	26		CAP
88160	Cytopathology, smears,	Cytopathology (	April 2015	36		
88161	Cytopathology, smears,	Cytopathology (	April 2015	36		
88162	Cytopathology, smears,	Cytopathology (	April 2015	36		
88184	Flow cytometry, cell su	Flow Cytometry	January 2016			CAP
88185	Flow cytometry, cell su	Flow Cytometry	January 2016			CAP
88187	Flow cytometry, interpr	Flow Cytometry	January 2016	42		CAP
88188	Flow cytometry, interpr	Flow Cytometry	January 2016	42		CAP
88189	Flow cytometry, interpr	Flow Cytometry	January 2016	42		CAP
88300	Level I - Surgical patholo	Pathology Cons	January 2012	24		AAD, AGA, CAP,
88302	Level II - Surgical pathol	Pathology Cons	January 2012	24		AAD, AGA, CAP,
88304	Level III - Surgical pathc	Pathology Cons	January 2012	24		AAD, AGA, CAP,
88305	Level IV - Surgical pathc	Pathology Cons	January 2012	24		AAD, AGA, CAP,

88307	Level V - Surgical patho	Pathology Cons	January 2012	24			AAD, AGA, CAP,
88309	Level VI - Surgical pathc	Pathology Servi	January 2012	24			AAD, AGA, CAP,
88312	Special stain including i	Special Stains	January 2012	33			CAP
88313	Special stain including i	Special Stains	February 2011	33			CAP
88314	Special stain including i	Special Stains	February 2011	33			CAP
88318	Deleted from CPT	Special Stains	February 2010	22			CAP, AAD
88319	Special stain including i	Special Stains	February 2011	33			CAP
88321	Consultation and repor	Microslide Cons	January 2016	43			CAP, ASC
88323	Consultation and repor	Microslide Cons	January 2016	43			CAP, ASC
88325	Consultation, comprehe	Microslide Cons	January 2016	43			CAP, ASC
88329	Pathology consultation	Pathology Cons	October 2010	18			CAP
88331	Pathology consultation	Pathology Cons	October 2010	18			CAP
88332	Pathology consultation	Pathology Cons	October 2010	18			CAP
88333	Pathology consultation	Pathology Cons	April 2016	39			ASC, CAP
88334	Pathology consultation	Pathology Cons	April 2016	39			ASC, CAP
88341	Immunohistochemistry	Morphometric /	April 2014	21			CAP
88342	Immunohistochemistry	Morphometric /	April 2014	21			CAP
88343	Immunohistochemistry	Morphometric /	April 2014	21			CAP
88344	Immunohistochemistry	Morphometric /	April 2014	21			CAP
88346	Immunofluorescence, p	Immunofluores	January 2015	17			CAP, ASC
88347	Immunofluorescent stu	Immunofluores	January 2015	17			CAP, ASC
88348	Electron microscopy, di	Electron Micros	October 2013	14			CAP
88349	Electron microscopy; sc	Electron Micros	October 2013	14			CAP
88350	Immunofluorescence, p	Immunofluores	January 2015	17			CAP, ASC
88356	Morphometric analysis,	RAW	April 2014	37			ASCP, CAP
88360	Morphometric analysis,	Tumor Immuno	April 2016	40			ASC, CAP
88361	Morphometric analysis,	Tumor Immuno	April 2016	40			ASC, CAP
88364	In situ hybridization (eg	Morphometric /	April 2014	21			CAP, ASCP, ASC
88365	In situ hybridization (eg	Morphometric /	April 2014	21			CAP
88366	In situ hybridization (eg	Morphometric /	April 2014	21			CAP, ASCP, ASC
88367	Morphometric analysis,	Morphometric /	September 201	18			CAP, ASCP, ASC
88368	Morphometric analysis,	Morphometric /	September 201	18			CAP, ASCP, ASC
88373	Morphometric analysis,	Morphometric /	April 2014	21			CAP, ASCP, ASC
88374	Morphometric analysis,	Morphometric /	April 2014	21			CAP, ASCP, ASC
88377	Morphometric analysis,	Morphometric /	October 2020	24			CAP, ASCP, ASC
90465	Deleted from CPT	Immunization A	February 2008	R			AAP
90467	Deleted from CPT	Immunization A	February 2008	R			AAP
90471	Immunization administi	Immunization A	February 2008	R			AAP
90472	Immunization administi	Immunization A	February 2008	R			AAP
90473	Immunization administi	Immunization A	February 2008	R			AAP
90474	Immunization administi	Immunization A	February 2008	R			AAP
90785	Interactive complexity (	Psychotherapy	January 2020	37	October 2023	RUC	APA, APA (HCP/
90791	Psychiatric diagnostic e	Psychotherapy	April 2012	26			APA, APA (HCP/
90792	Psychiatric diagnostic e	Psychotherapy	April 2012	26			APA, APA (HCP/
90801	Psychiatric diagnostic ir	RAW review	January 2012	30			
90805	Individual psychotherap	RAW review	January 2012	30			
90806	Individual psychotherap	RAW review	January 2012	30			

90808	Individual psychotherap	RAW review	January 2012	30			
90818	Individual psychotherap	RAW review	January 2012	30			
90832	Psychotherapy, 30 minu	Psychotherapy	April 2012	26			APA, APA (HCPA
90833	Psychotherapy, 30 minu	Psychotherapy	April 2012	26			APA, APA (HCPA
90834	Psychotherapy, 45 minu	Psychotherapy	April 2012	26			APA, APA (HCPA
90836	Psychotherapy, 45 minu	Psychotherapy	April 2012	26			APA, APA (HCPA
90837	Psychotherapy, 60 minu	Psychotherapy	April 2012	26			APA, APA (HCPA
90838	Psychotherapy, 60 minu	Psychotherapy	April 2012	26			APA, APA (HCPA
90839	Psychotherapy for crisis	Psychotherapy	April 2013	35			APA, APA (HCPA
90840	Psychotherapy for crisis	Psychotherapy	April 2013	35			APA, APA (HCPA
90845	Psychoanalysis	Psychotherapy	October 2011				
90846	Family psychotherapy (	Psychotherapy	April 2012	26			APA, APA (HCPA
90847	Family psychotherapy (	Psychotherapy	April 2012	26			APA, APA (HCPA
90853	Group psychotherapy (o	Psychotherapy	April 2012	26			APA, APA (HCPA
90862	Pharmacologic manage	RAW review	January 2012	30			
90863	Pharmacologic manage	Pharmacologic	April 2013	40			APA (HCPAC)
90868	Therapeutic repetitive transcranial mag		October 2020	23	October 2023	RAW	
90870	Electroconvulsive thera	Electroconvulsi	April 2010	41			APA
90911	Biofeedback training, p	Biofeedback Tra	January 2019	15			ACOG, AUA
90912	Biofeedback training, p	Biofeedback Tra	January 2019	15			
90913	Biofeedback training, p	Biofeedback Tra	January 2019	15			
90935	Hemodialysis procedur	Hemodialysis-D	October 2009	30			RPA
90937	Hemodialysis procedur	Hemodialysis-D	October 2009	30			RPA
90945	Dialysis procedure othe	Hemodialysis-D	October 2009	30			RPA
90947	Dialysis procedure othe	Hemodialysis-D	October 2009	30			RPA
90951	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90952	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90953	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90954	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90955	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90956	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90957	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90958	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90959	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90960	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90961	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90962	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90963	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90964	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90965	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
90966	End-stage renal disease	End-Stage Rena	April 2009	29			RPA
91038	Esophageal function tes	Gastroenterolo	February 2010	23			AGA, ASGE
91110	Gastrointestinal tract in	Gastrointestina	January 2016	44			ACG, AGA, ASGE
91111	Gastrointestinal tract in	Gastrointestina	January 2016	44			ACG, AGA, ASGE
91132	Electrogastrography, di	Electrogastrogr	February 2010	24			AGA, ACG, ASGE
91133	Electrogastrography, di	Electrogastrogr	February 2010	24			AGA, ACG, ASGE
92065	Orthoptic and/or pleop	Orthoptic Traini	October 2020	09	April 2021	RUC	AAO, AOA (optc

92081	Visual field examinatior	Visual Field Exa	April 2010	42			AAO, AOA (optc
92082	Visual field examinatior	Visual Field Exa	April 2010	42			AAO, AOA (optc
92083	Visual field examinatior	Visual Field Exa	April 2012	46			AAO, AOA (optc
92100	Serial tonometry (separ	Serial Tonomet	September 201	36			AAO, AOA (optc
92133	Scanning computerized	Computerized S	April 2010	23			AAO, AOA (eye)
92134	Scanning computerized	Computerized S	April 2010	23			AAO, AOA (eye)
92135	Deleted from CPT	Ophthalmic Dia	October 2009	31			AAO, AOA
92136	Ophthalmic biometry b	Ophthalmic Bio	April 2016	36			AAO
92140	Provocative tests for gl	Glaucoma Prov	April 2016	41			AAO, AOA (optc
92201	Ophthalmoscopy, exter	Ophthalmoscop	April 2018	05			AAO, AOA (Optc
92202	Ophthalmoscopy, exter	Ophthalmoscop	April 2018	05			AAO, AOA (Optc
92225	Ophthalmoscopy, exter	Ophthalmoscop	April 2018	05			AAO, AOA (Optc
92226	Ophthalmoscopy, exter	Ophthalmoscop	April 2018	05			AAO, AOA (Optc
92235	Fluorescein angiograph	Ophthalmoscop	January 2016	21		RUC	AAO, ASRS
92240	Indocyanine-green angi	Ophthalmoscop	January 2016	21		RUC	AAO, ASRS
92242	Fluorescein angiograph	Ophthalmoscop	January 2016	21		RUC	AAO, ASRS
92250	Fundus photography wi	Fundus Photogr	January 2016	45			AAO, ASRS, AOA
92270	Electro-oculography wi	Electro-oculogr	October 2017	19			AAO-HNS
92273	Electroretinography (EF	Electroretinogr	January 2021	29	January 2024	RAW	
92274	Electroretinography (EF	Electroretinogr	January 2021	29	January 2024	RAW	
92275	Electroretinography wit	Electroretinogr	January 2018	17			AAO, ASRS, AOA
92284	Dark adaptation examination with inter		January 2021	29	April 2021	RUC	
92285	External ocular photogr	Ocular Photogr	October 2009	32			AAO, AOA
92286	Anterior segment imagi	Anterior Segme	April 2012	28			AAO, AOA (optc
92287	Anterior segment imagi	Anterior Segme	January 2021	29	April 2021	RUC	AAO, AOA (optc
92504	Binocular microscopy (s	Binocular Micro	April 2010	43			AAO-HNS
92506	Evaluation of speech, la	Speech Langua	February 2010	28			ASHA
92507	Treatment of speech, la	Speech Langua	January 2016	54			ASHA
92508	Treatment of speech, la	Speech Langua	February 2010	28			ASHA
92521	Evaluation of speech flu	Speech Evaluati	January 2013	32			ASHA
92522	Evaluation of speech so	Speech Evaluati	January 2013	32			ASHA
92523	Evaluation of speech so	Speech Evaluati	January 2013	32			ASHA
92524	Behavioral and qualitat	Speech Evaluati	January 2013	32			ASHA
92526	Treatment of swallowir	Speech Langua	October 2020	23			ASHA, AAO-HNS
92537	Caloric vestibular test w	Vestibular Calor	January 2015	18			AAA, AAN, AAO
92538	Caloric vestibular test w	Vestibular Calor	January 2015	18			AAA, AAN, AAO
92540	Basic vestibular evaluat	EOG VNG	April 2014	24			AAN, ASHA, AAC
92541	Spontaneous nystagmu	EOG VNG	April 2014	24			AAN, ASHA, AAC
92542	Positional nystagmus te	EOG VNG	April 2014	24			AAN, ASHA, AAC
92543	Caloric vestibular test, e	Vestibular Calor	January 2015	18			AAA, AAN, AAO
92544	Optokinetic nystagmus	EOG VNG	April 2014	24			AAN, ASHA, AAC
92545	Oscillating tracking test	EOG VNG	April 2014	24			AAN, ASHA, AAC
92546	Sinusoidal vertical axis r	EOG VNG	April 2014	24			
92547	Use of vertical electrod	EOG VNG	April 2014	24			
92548	Computerized dynamic	Computerized D	January 2019	16			AAA, AAN, ASHA
92549	Computerized dynamic	Computerized D	January 2019	16		RUC	
92550	Tympanometry and refl	Bundled Audiol	April 2009	22			ASHA, AAO-HNS

92557	Comprehensive audiom	Bundled Audiol	April 2009	22	ASHA, AAO-HNS
92558	Evoked otoacoustic em	Otoacoustic Em	April 2011	35	ASHA
92567	Tympanometry (imped	Bundled Audiol	April 2009	22	ASHA, AAO-HNS
92568	Acoustic reflex testing,	Bundled Audiol	April 2009	22	ASHA, AAO-HNS
92569	Deleted from CPT	Bundled Audiol	April 2009	22	ASHA, AAO-HNS
92570	Acoustic immittance te	Bundled Audiol	October 2015	21	ASHA, AAO-HNS
92584	Electrocochleography	Auditory Evoke	April 2019	06	AAA, AAO-HNS,
92585	Auditory evoked potent	Auditory Evoke	April 2019	06	AAA, AAO-HNS,
92586	Auditory evoked potent	Auditory Evoke	April 2019	06	AAA, AAO-HNS,
92587	Distortion product evol	Otoacoustic Em	April 2011	35	ASHA
92588	Distortion product evol	Otoacoustic Em	April 2011	35	ASHA
92597	Evaluation for use and/	Speech Langua	February 2009	30	ASHA
92605	Evaluation for prescript	Eval of Rx for N	April 2011	35	ASHA
92606	Therapeutic service(s) f	Speech Langua	February 2010	28	ASHA
92607	Evaluation for prescript	Speech Langua	February 2010	28	ASHA
92608	Evaluation for prescript	Speech Langua	February 2010	28	ASHA
92609	Therapeutic services fo	Speech Langua	February 2010	28	ASHA
92610	Evaluation of oral and p	Speech Langua	October 2020	23	ASHA, AAO-HNS
92611	Motion fluoroscopic ev	Speech Langua	April 2009	39	ASHA
92618	Evaluation for prescript	Eval of Rx for N	April 2011	35	ASHA
92620	Evaluation of central au	Audiology Servi	October 2008	17	ASHA, AAO-HNS
92621	Evaluation of central au	Audiology Servi	October 2008	17	ASHA, AAO-HNS
92625	Assessment of tinnitus	Audiology Servi	October 2008	17	ASHA, AAO-HNS
92626	Evaluation of auditory f	Audiology Servi	October 2018	30	AAA, ASHA
92627	Evaluation of auditory f	Audiology Servi	October 2018	30	ASHA, AAO-HNS
92640	Diagnostic analysis with	Audiology Servi	October 2008	17	ASHA, AAO-HNS
92650	Auditory evoked potent	Auditory Evoke	April 2019	06	AAA, AAO-HNS,
92651	Auditory evoked potent	Auditory Evoke	April 2019	06	AAA, AAO-HNS,
92652	Auditory evoked potent	Auditory Evoke	April 2019	06	AAA, AAO-HNS,
92653	Auditory evoked potent	Auditory Evoke	April 2019	06	AAA, AAN, AAO
92920	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92921	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92924	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92925	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92928	Percutaneous transcath	Percutaneous C	January 2012	10	ACC
92929	Percutaneous transcath	Percutaneous C	January 2012	10	ACC
92933	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92934	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92937	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92938	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92941	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92943	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92944	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92960	Cardioversion, elective,	Cardioversion	October 2010	19	ACC
92973	Percutaneous translum	RAW	October 2017	19	
92980	Transcatheter placeme	Percutaneous C	January 2012	10	ACC
92981	Transcatheter placeme	Percutaneous C	January 2012	10	ACC

92982	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92984	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92986	Percutaneous balloon v	Valvuloplasty	October 2008	26	ACC
92992	Atrial septectomy or se	Atrial Septostor	January 2020	13	
92993	Atrial septectomy or se	Atrial Septostor	January 2020	13	
92995	Percutaneous translum	Percutaneous C	January 2012	10	ACC
92996	Percutaneous translum	Percutaneous C	January 2012	10	ACC
93000	Electrocardiogram, rou	Complete Electı	April 2019	20	ACC
93005	Electrocardiogram, rou	Complete Electı	April 2019	20	ACC
93010	Electrocardiogram, rou	Complete Electı	April 2019	20	ACC
93012	Deleted from CPT	External Cardio	April 2010	25	ACC
93014	Deleted from CPT	External Cardio	April 2010	25	ACC
93015	Cardiovascular stress te	Cardiovascular !	April 2012	47	ACC
93016	Cardiovascular stress te	Cardiovascular !	April 2012	47	ACC
93017	Cardiovascular stress te	Cardiovascular !	April 2010	45	ACC
93018	Cardiovascular stress te	Cardiovascular !	April 2012	47	ACC
93025	Microvolt T-wave alterr	Microvolt T-Wa	October 2008	18	ACC
93040	Rhythm ECG, 1-3 leads;	Rhythm EKG	October 2009	34	ACC
93041	Rhythm ECG, 1-3 leads;	Rhythm EKG	October 2009	34	ACC
93042	Rhythm ECG, 1-3 leads;	Rhythm EKG	October 2009	34	ACC, ACEP
93224	External electrocardiog	External Cardio	April 2010	25	ACC
93225	External electrocardiog	External Cardio	April 2010	25	ACC
93226	External electrocardiog	External Cardio	April 2010	25	ACC
93227	External electrocardiog	External Cardio	April 2010	25	ACC
93228	External mobile cardiov	External Cardio	October 2020	20	ACC, HRS
93229	External mobile cardiov	External Cardio	October 2020	20	ACC, HRS
93230	Deleted from CPT	Cardiac Device I	April 2009	31	ACC
93231	Deleted from CPT	External Cardio	April 2010	25	
93232	Deleted from CPT	External Cardio	April 2010	25	
93233	Deleted from CPT	Cardiac Device I	April 2009	31	ACC
93235	Deleted from CPT	External Cardio	April 2010	25	
93236	Deleted from CPT	Cardiovascular !	April 2009	38	ACC
93237	Deleted from CPT	Wearable Cardi	February 2010	31	ACC
93268	External patient and, w	External Cardio	April 2010	25	ACC
93270	External patient and, w	External Cardio	April 2010	25	ACC
93271	External patient and, w	External Cardio	April 2010	25	ACC
93272	External patient and, w	External Cardio	April 2010	25	ACC
93279	Programming device ev	Cardiac Electro	October 2016	25	ACC, HRS
93280	Programming device ev	Cardiac Electro	October 2016	25	ACC, HRS
93281	Programming device ev	Cardiac Electro	October 2016	25	ACC, HRS
93282	Programming device ev	Cardiac Electro	October 2016	25	ACC, HRS
93283	Programming device ev	Cardiac Electro	October 2016	25	ACC, HRS
93284	Programming device ev	Cardiac Electro	October 2016	25	ACC, HRS
93285	Programming device ev	Cardiac Electro	October 2016	25	ACC, HRS
93286	Peri-procedural device	Cardiac Electro	October 2016	25	ACC, HRS
93287	Peri-procedural device	Cardiac Electro	October 2016	25	ACC, HRS
93288	Interrogation device ev	Cardiac Electro	October 2016	25	ACC, HRS

93289	Interrogation device ev	Cardiac Electrop	October 2016	25		ACC, HRS
93290	Interrogation device ev	Cardiac Electrop	October 2016	25		ACC, HRS
93291	Interrogation device ev	Cardiac Electrop	October 2016	25		ACC, HRS
93292	Interrogation device ev	Cardiac Electrop	October 2016	25		ACC, HRS
93293	Transtelephonic rhythm	Cardiac Electrop	January 2017	23		ACC, HRS
93294	Interrogation device ev	Cardiac Electrop	January 2017	23		ACC, HRS
93295	Interrogation device ev	Cardiac Electrop	January 2017	23		ACC, HRS
93296	Interrogation device ev	Cardiac Electrop	October 2016	25		ACC, HRS
93297	Interrogation device ev	Cardiac Electrop	January 2017	23		ACC, HRS
93298	Interrogation device ev	Cardiac Electrop	January 2017	23		ACC, HRS
93299	Interrogation device ev	Cardiac Electrop	October 2018	22		ACC, HRS
93306	Echocardiography, tran	Complete Trans	April 2019	21		ACC, ASE
93307	Echocardiography, tran	Transthoracic E	April 2016	42		ACC
93308	Echocardiography, tran	Transthoracic E	April 2016	42		ACC
93320	Doppler echocardiograp	Doppler Echoca	January 2014	30		ACC
93321	Doppler echocardiograp	Doppler Echoca	January 2014	30		ACC
93325	Doppler echocardiograp	Doppler Echoca	January 2014	30		ACC
93350	Echocardiography, tran	Stress Transtho	October 2016	26	RUC	ACC, ASE
93351	Echocardiography, tran	Stress Transtho	October 2016	26	RUC	ACC, ASE
93451	Right heart catheterizat	Diagnostic Card	April 2018	33		ACC
93452	Left heart catheterizati	Diagnostic Card	April 2011	28		ACC
93453	Combined right and left	Diagnostic Card	April 2011	28		ACC
93454	Catheter placement in c	Diagnostic Card	April 2011	28		ACC
93455	Catheter placement in c	Diagnostic Card	April 2011	28		ACC
93456	Catheter placement in c	Diagnostic Card	April 2018	33		ACC
93457	Catheter placement in c	Diagnostic Card	April 2011	28		ACC
93458	Catheter placement in c	Diagnostic Card	April 2011	28		ACC
93459	Catheter placement in c	Diagnostic Card	April 2011	28		ACC
93460	Catheter placement in c	Diagnostic Card	April 2011	28		ACC
93461	Catheter placement in c	Diagnostic Card	April 2011	28		ACC
93462	Left heart catheterizati	Diagnostic Card	April 2011	28		ACC
93463	Pharmacologic agent ac	Diagnostic Card	April 2011	28		ACC
93464	Physiologic exercise stu	Diagnostic Card	April 2011	28		ACC
93501	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC
93503	Insertion and placemen	Insertion of Cat	April 2018	33		ACR, ASA
93508	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC
93510	Deleted from CPT	Cardiac Cathete	February 2009	31		ACC
93511	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC
93514	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC
93524	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC
93526	Deleted from CPT	Cardiac Cathete	February 2008	S		ACC
93527	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC
93528	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC
93529	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC
93539	Deleted from CPT	Cardiac Cathete	February 2008	S		ACC
93540	Deleted from CPT	Cardiac Cathete	February 2008	S		ACC
93541	Deleted from CPT	Cardiac Cathete	April 2010	26		ACC

93542	Deleted from CPT	Cardiac Cathete	April 2010	26			ACC
93543	Deleted from CPT	Cardiac Cathete	February 2009	31			ACC
93544	Deleted from CPT	Cardiac Cathete	February 2008	S			ACC
93545	Deleted from CPT	Cardiac Cathete	February 2009	31			ACC
93555	Deleted from CPT	Cardiac Cathete	February 2009	31			ACC
93556	Deleted from CPT	Cardiac Cathete	February 2009	31			ACC
93561	Indicator dilution studie	Cardiac Output	January 2018	27			
93562	Indicator dilution studie	Cardiac Output	January 2018	27			
93563	Injection procedure dur	Diagnostic Card	April 2011	28			ACC
93564	Injection procedure dur	Diagnostic Card	April 2011	28			ACC
93565	Injection procedure dur	Diagnostic Card	April 2011	28			ACC
93566	Injection procedure dur	Diagnostic Card	April 2011	28			ACC
93567	Injection procedure dur	Diagnostic Card	April 2011	28			ACC
93568	Injection procedure dur	Diagnostic Card	April 2011	28			ACC
93571	Intravascular Doppler v	Coronary Flow I	October 2017	13			ACC, SCAI
93572	Intravascular Doppler v	Coronary Flow I	October 2017	13			ACC, SCAI
93613	Intracardiac electrophy	Intracardiac 3D	January 2017	24		RUC	ACC, HRS
93620	Comprehensive electro	Intracardiac Cat	April 2010	45			ACC
93621	Comprehensive electro	Electrophysiolo	October 2020	21			
93623	Programmed stimulatic	Pacing Heart Sti	April 2019	22			ACC, HRS
93641	Electrophysiologic evalu	Insertion/Remo	September 201	21			ACC
93651	Intracardiac catheter ab	Bundling EPS wi	January 2012	11			ACC, HRS
93652	Intracardiac catheter ab	Bundling EPS wi	January 2012	11			ACC, HRS
93653	Comprehensive electro	Cardiac Ablatio	January 2021	22	April 2021	RUC	ACC, HRS
93654	Comprehensive electro	Cardiac Ablatio	January 2021	22	April 2021	RUC	ACC, HRS
93655	Intracardiac catheter ab	Cardiac Ablatio	January 2021	22	April 2021	RUC	ACC, HRS
93656	Comprehensive electro	Cardiac Ablatio	January 2021	22	April 2021	RUC	ACC, HRS
93657	Additional linear or foc	Cardiac Ablatio	January 2021	22	April 2021	RUC	ACC, HRS
93662	Intracardiac echocardio	Intracardiac Ech	April 2019	23			ACC, HRS
93668	Peripheral arterial dise	Peripheral Arte	January 2018	28			
93701	Bioimpedance-derived physiologic card		February 2011	41			
93731	Deleted from CPT	Cardiology Serv	October 2008	26			ACC
93732	Deleted from CPT	Cardiology Serv	October 2008	26			ACC
93733	Deleted from CPT	Cardiology Serv	October 2008	26			ACC
93743	Deleted from CPT	Cardiology Serv	October 2008	26			ACC
93744	Deleted from CPT	Cardiology Serv	October 2008	26			ACC
93750	Interrogation of ventric	Ventricular Assi	April 2019	24			AATS, ACC, STS
93792	Patient/caregiver traini	Home INR Mon	January 2020	37	January 2022	RAW	
93793	Anticoagulant manager	Home INR Mon	January 2020	37	January 2022	RAW	
93875	Deleted from CPT	Noninvasive Va	April 2010	45			AAN, ACC, ACR,
93880	Duplex scan of extracra	Duplex Scans	April 2014	33			ACR, ACC, SVS
93882	Duplex scan of extracra	Duplex Scans	April 2014	33			ACC, ACR, SVS
93886	Transcranial Doppler st	Duplex Scans	April 2014	33			AAN, ACC, ACR,
93888	Transcranial Doppler st	Duplex Scans	April 2014	33			AAN, ACC, ACR,
93890	Transcranial Doppler study of the intrac		January 2020	37			
93892	Transcranial Doppler study of the intrac		January 2020	37			
93895	Quantitative carotid int	Carotid Intima-I	April 2015	37		RUC	No Interest

93922	Limited bilateral noninv	Extremity Non-I	April 2010	27	SVS, ACR, ACC
93923	Complete bilateral noni	Extremity Non-I	April 2010	27	SVS, ACR, ACC
93924	Noninvasive physiologic	Extremity Non-I	April 2010	27	SVS, ACR, ACC
93925	Duplex scan of lower ex	Duplex Scans	April 2014	33	ACC, ACR, SVS
93926	Duplex scan of lower ex	Duplex Scans	April 2014	33	ACC, ACR, SVS
93930	Duplex scan of upper ex	Duplex Scans	April 2014	33	AAN, ACC, ACR,
93931	Duplex scan of upper ex	Duplex Scans	April 2014	33	AAN, ACC, ACR,
93965	Noninvasive physiologic	Non-invasive Ph	January 2016	47	ACC, ACR, SCAI,
93970	Duplex scan of extremit	Duplex Scans	April 2014	33	ACC, ACR, SVS
93971	Duplex scan of extremit	Duplex Scans	April 2014	33	ACR, SVS, ACC
93975	Duplex scan of arterial i	Duplex Scans	April 2014	33	ACR, SVS, ACC
93976	Duplex scan of arterial i	Duplex Scans	April 2014	33	ACR
93978	Duplex scan of aorta, in	Duplex Scans	April 2014	33	
93979	Duplex scan of aorta, in	Duplex Scans	April 2014	33	
93982	Noninvasive physiologic	Endovascular Re	January 2017	10	SVS, SIR, STS, AA
93985	Duplex scan of arterial i	Duplex Scan Art	January 2019	17	
93986	Duplex scan of arterial i	Duplex Scan Art	January 2019	17	
93990	Duplex scan of hemodia	Doppler Flow Te	April 2014	40	ACR, SVS
94010	Spirometry, including g	Spirometry	October 2019	12	ATS, CHEST
94014	Patient-initiated spirom	Pulmonary Test	February 2009	38	ACCP/ATS
94015	Patient-initiated spirom	Pulmonary Test	February 2009	38	ACCP/ATS
94016	Patient-initiated spirom	Pulmonary Test	February 2009	38	ACCP/ATS
94060	Bronchodilation respon	Spirometry	October 2019	12	ATS, CHEST
94200	Maximum breathing ca	Lung Function T	April 2018	28	ATS, CHEST
94240	Deleted from CPT	Pulmonary Test	April 2010	45	ACCP, ATS
94250	Expired gas collection, c	RAW	October 2019	17	
94260	Deleted from CPT	Pulmonary Test	April 2010	45	ACCP, ATS
94350	Deleted from CPT	Pulmonary Test	April 2010	45	ACCP, ATS
94360	Deleted from CPT	Pulmonary Test	April 2010	45	ACCP, ATS
94370	Determination of airwa	Pulmonary Test	April 2010	45	ACCP, ATS
94400	Breathing response to c	Evaluation of W	April 2019	25	ATS, CHEST
94450	Breathing response to h	Pulmonary Test	February 2009	38	ACCP/ATS
94617	Exercise test for bronch	Pulmonary Diag	October 2016	05	ATS, CHEST
94618	Pulmonary stress testin	Pulmonary Diag	October 2016	05	ATS, CHEST
94620	Pulmonary stress testin	Pulmonary Diag	October 2016	05	ATS, CHEST
94621	Cardiopulmonary exerc	Pulmonary Diag	October 2016	05	ATS, CHEST
94640	Pressurized or nonpress	Evaluation of W	April 2019	25	AAFP, ATS, CHES
94667	Manipulation chest wal	Evaluation of W	April 2019	25	ATS, CHEST
94668	Manipulation chest wal	Evaluation of W	April 2019	25	AAFP, ATS, CHES
94669	Mechanical chest wall c	Evaluation of W	April 2019	25	ATS, CHEST
94681	Oxygen uptake, expired	Pulmonary Test	September 201	51	AACE, TES, ACCI
94720	Carbon monoxide diffus	Pulmonary Test	April 2010	45	ACCP, ATS
94725	Membrane diffusion ca	Pulmonary Test	April 2010	45	ACCP, ATS
94726	Plethysmography for de	Pulmonary Func	April 2011	19	ACCP, ATS
94727	Gas dilution or washout	Pulmonary Func	April 2011	19	ACCP, ATS
94728	Airway resistance by os	Pulmonary Func	April 2011	19	ACCP, ATS
94729	Diffusing capacity (eg, c	Pulmonary Func	April 2011	19	ACCP, ATS

94750	Pulmonary compliance	RAW	October 2019	17			
94760	Noninvasive ear or puls	Measure Blood	February 2009	32			ACCP, ATS
94761	Noninvasive ear or puls	Measure Blood	February 2009	32			ACCP, ATS
94762	Noninvasive ear or puls	Measure Blood	February 2009	32			ACCP, ATS
94770	Carbon dioxide, expirec	Evaluation of W	April 2019	25			ATS, CHEST
95004	Percutaneous tests (scr	Percutaneous A	October 2016	27		RUC	AAAAI, AAOA, A
95010	Percutaneous tests (scr	Percutaneous A	April 2011	31			JCAAI, ACAAI, A
95012	Nitric oxide expired gas	Exhaled Nitric C	April 2019	26			AAAAI, ACAAI, A
95015	Intracutaneous (intrade	Intracutaneous	April 2011	31			JCAAI, ACAAI, A
95017	Allergy testing, any con	Percutaneous A	April 2012	29			JCAAI
95018	Allergy testing, any con	Percutaneous A	April 2012	29			JCAAI
95024	Intracutaneous (intrade	Intracutaneous	October 2017	19			JCAAI, ACAAI, A
95027	Intracutaneous (intrade	Intracutaneous	February 2011	41			JCAAI, ACAAI, A
95115	Professional services fo	Immunotherap	April 2012	48			JCAAI, AAOA
95117	Professional services fo	Immunotherap	April 2012	48			JCAAI, AAOA
95144	Professional services fo	Antigen Therap	January 2016	49			AAOHNS, AAOA
95148	Professional services for the supervisio		October 2010	73			
95165	Professional services fo	Antigen Therap	January 2016	49			AAOHNS, AAOA
95249	Ambulatory continuous	Continuous Glu	April 2017	08			AACE, ES, ACP
95250	Ambulatory continuous	Continuous Glu	January 2020	37	January 2023	RAW	AACE, ES
95251	Ambulatory continuous	Continuous Glu	January 2020	37	January 2023	RAW	AACE, ES
95700	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95705	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95706	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95707	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95708	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95709	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95710	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95711	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95712	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95713	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95714	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95715	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95716	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95717	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95718	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95719	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95720	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95721	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95722	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95723	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95724	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95725	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95726	Electroencephalogram	Long-Term EEG	October 2018	13			AAN, ACNS
95800	Sleep study, unattende	Sleep Testing	April 2010	28			ACNS, AAN, AC
95801	Sleep study, unattende	Sleep Testing	April 2010	28			ACNS, AAN, AC
95803	Actigraphy testing, recc	Sleep Testing	April 2010	28			ACNS, AAN, AC

95805	Multiple sleep latency c	Sleep Testing	April 2010	28		ACNS, AAN, ACC
95806	Sleep study, unattende	Sleep Testing	April 2010	28		ACNS, AAN, ACC
95807	Sleep study, simultanec	Sleep Testing	April 2010	28		ACNS, AAN, ACC
95808	Polysomnography; any	Sleep Testing	April 2010	28		ACNS, AAN, ACC
95810	Polysomnography; age	Sleep Testing	April 2010	28		ACNS, AAN, ACC
95811	Polysomnography; age	Sleep Testing	April 2010	28		ACNS, AAN, ACC
95812	Electroencephalogram	Long-Term EEG	October 2018	13		AAN, ACNS
95813	Electroencephalogram	Long-Term EEG	October 2018	13		AAN, ACNS
95816	Electroencephalogram	Electroencepha	October 2012	22		
95819	Electroencephalogram	Electroencepha	October 2012	22		AAN, ACNS
95822	Electroencephalogram	Electroencepha	October 2012	22		AAN, ACNS
95827	Electroencephalogram	Long-Term EEG	October 2018	13		AAN, ACNS
95831	Muscle testing, manual	Muscle Testing	April 2018	33		AAN, AANEM, A
95832	Muscle testing, manual	Muscle Testing	April 2018	33		AAN, AANEM, A
95833	Muscle testing, manual	Muscle Testing	April 2018	33		AAN, AANEM, A
95834	Muscle testing, manual	Muscle Testing	April 2018	33		AAN, AANEM, A
95860	Needle electromyograp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95861	Needle electromyograp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95863	Needle electromyograp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95864	Needle electromyograp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95867	Needle electromyograp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95868	Needle electromyograp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95869	Needle electromyograp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95870	Needle electromyograp	EMG in Conjunc	October 2017	19		AAN, AAPMR, A
95885	Needle electromyograp	EMG in Conjunc	April 2011	20		AAN, AAPMR, A
95886	Needle electromyograp	EMG in Conjunc	April 2011	20		AAN, AAPMR, A
95887	Needle electromyograp	EMG in Conjunc	April 2011	20		AAN, AAPMR, A
95900	Nerve conduction, amp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95903	Nerve conduction, amp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95904	Nerve conduction, amp	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95907	Nerve conduction studi	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95908	Nerve conduction studi	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95909	Nerve conduction studi	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95910	Nerve conduction studi	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95911	Nerve conduction studi	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95912	Nerve conduction studi	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95913	Nerve conduction studi	EMG in Conjunc	April 2012	32		AAN, AAPMR, A
95921	Testing of autonomic n	Autonomic Fun	January 2020	37	October 2023 RAW	AAFP, AAN, AAN
95922	Testing of autonomic n	Autonomic Fun	January 2020	37	October 2023 RAW	AAFP, AAN, AAN
95923	Testing of autonomic n	Autonomic Fun	January 2020	37	October 2023 RAW	AAFP, AAN, AAN
95924	Testing of autonomic n	Autonomic Fun	January 2020	37	October 2023 RAW	AAFP, AAN, AAN
95925	Short-latency somatose	Evoked Potentia	January 2013	34		AAN, AANEM, A
95926	Short-latency somatose	Evoked Potentia	January 2013	34		AAN, AANEM, A
95928	Central motor evoked p	Evoked Potentia	April 2013	36		AAN, AANEM, A
95929	Central motor evoked p	Evoked Potentia	April 2013	36		AAN, AANEM, A
95930	Visual evoked potential	Visual Evoked P	October 2016	11		AAO, AOA (optc
95934	H-reflex, amplitude and	EMG in Conjunc	April 2012	32		

95936	H-reflex, amplitude and	EMG in Conjunc	April 2012	32	
95938	Short-latency somatose	Evoked Potentia	January 2013	34	AAN, AANEM, A
95939	Central motor evoked p	Evoked Potentia	January 2013	34	AAN, AANEM, A
95940	Continuous intraoperat	Intraoperative M	January 2012	12	
95941	Continuous intraoperat	Intraoperative M	January 2012	12	
95943	Simultaneous, indepen	Autonomic Fun	January 2020	37	AAN, AANEM
95950	Monitoring for identific	Long-Term EEG	October 2018	13	AAN, ACNS
95951	Monitoring for localizat	Long-Term EEG	October 2018	13	
95953	Monitoring for localizat	Long-Term EEG	October 2018	13	AAN, ACNS
95954	Pharmacological or phy	EEG Monitoring	February 2008	S	AAN, ACNS
95956	Monitoring for localizat	Long-Term EEG	October 2018	13	AAN, ACNS
95957	Digital analysis of electr	Electroencepha	January 2016	50	AAN
95970	Electronic analysis of in	Neurostimulato	January 2019	37	AAN, AANS/CNS
95971	Electronic analysis of in	Neurostimulato	October 2017	07	AUA, ACOG, AA
95972	Electronic analysis of in	Neurostimulato	October 2017	07	AUA, ACOG, AA
95973	Electronic analysis of in	Implanted Neur	April 2015	21	AANS/CNS, ACC
95974	Electronic analysis of in	Neurostimulato	October 2017	07	AAN, AANS/CNS
95975	Electronic analysis of in	Neurostimulato	October 2017	07	AAN, AANS/CNS
95976	Electronic analysis of in	Neurostimulato	October 2017	07	AAN, AANS/CNS
95977	Electronic analysis of in	Neurostimulato	October 2017	07	AAN, AANS/CNS
95978	Electronic analysis of in	Neurostimulato	October 2017	07	AAN, AANS/CNS
95979	Electronic analysis of in	Neurostimulato	October 2017	07	AAN, AANS/CNS
95980	Electronic analysis of in	Neurostimulato	October 2017	07	No Interest
95981	Electronic analysis of in	Neurostimulato	October 2017	07	No Interest
95982	Electronic analysis of in	Neurostimulato	January 2016	07	No Interest
95983	Electronic analysis of in	Neurostimulato	October 2017	07	AAN, AANS/CNS
95984	Electronic analysis of in	Neurostimulato	October 2017	07	AAN, AANS/CNS
95990	Refilling and maintenan	Electronic Analy	February 2011	07	ASA, AAPM, NA
95991	Refilling and maintenan	Electronic Analy	February 2011	07	ASA, AAPM
95992	Canalith repositioning procedure(s) (eg,		April 2018	33	
96101	Psychological testing (ir	Psychological a	October 2017	08	APA (psycholog
96102	Psychological testing (ir	Psychological a	October 2017	08	APA (psycholog
96103	Psychological testing (ir	Psychological a	October 2017	08	APA (psycholog
96105	Assessment of aphasia	Psychological a	October 2017	20	APA (psycholog
96110	Developmental screeni	Psychological a	October 2017	08	APA (psycholog
96111	Developmental testing,	Psychological a	October 2017	08	APA (psycholog
96112	Developmental test adr	Psychological a	October 2017	08	APA (psycholog
96113	Developmental test adr	Psychological a	October 2017	08	APA (psycholog
96116	Neurobehavioral status	Psychological a	October 2017	08	APA (psycholog
96118	Neuropsychological tes	Psychological a	October 2017	08	APA (psycholog
96119	Neuropsychological tes	Psychological a	October 2017	08	APA (psycholog
96120	Neuropsychological tes	Psychological a	October 2017	08	APA (psycholog
96121	Neurobehavioral status	Psychological a	October 2017	08	APA (psycholog
96125	Standardized cognitive	Psychological a	October 2017	20	APA (psycholog
96127	Brief emotional/behavi	Psychological a	October 2017	08	APA (psycholog
96130	Psychological testing ev	Psychological a	October 2017	20	APA (psycholog
96131	Psychological testing ev	Psychological a	October 2017	20	APA (psycholog

96132	Neuropsychological tes	Psychological a	October 2017	08	APA (psycholog
96133	Neuropsychological tes	Psychological a	October 2017	08	APA (psycholog
96136	Psychological or neurop	Psychological a	October 2017	20	APA (psycholog
96137	Psychological or neurop	Psychological a	October 2017	20	APA (psycholog
96138	Psychological or neurop	Psychological a	October 2017	20	APA (psycholog
96139	Psychological or neurop	Psychological a	October 2017	20	APA (psycholog
96146	Psychological or neurop	Psychological a	October 2017	20	APA (psycholog
96150	Health and behavior ass	Health and Beh	January 2019	41	
96151	Health and behavior ass	Health and Beh	January 2019	41	
96152	Health and behavior int	Health and Beh	January 2019	41	
96153	Health and behavior int	Health and Beh	January 2019	41	
96154	Health and behavior int	Health and Beh	January 2019	41	APA (psycholog
96155	Health and behavior int	Health and Beh	January 2019	41	
96156	Health behavior assess	Health and Beh	January 2019	41	
96158	Health behavior interve	Health and Beh	January 2019	41	
96159	Health behavior interve	Health and Beh	January 2019	41	
96164	Health behavior interve	Health and Beh	January 2019	41	
96165	Health behavior interve	Health and Beh	January 2019	41	
96167	Health behavior interve	Health and Beh	January 2019	41	
96168	Health behavior interve	Health and Beh	January 2019	41	
96170	Health behavior interve	Health and Beh	January 2019	41	
96171	Health behavior interve	Health and Beh	January 2019	41	
96360	Intravenous infusion, h	IV Hydration	January 2017	25	ASCO, ASH
96361	Intravenous infusion, h	IV Hydration	January 2017	25	ASCO, ASH
96365	Intravenous infusion, fc	Intravenous Infu	January 2013	28	ACRh, ASCO, AS
96366	Intravenous infusion, fc	Intravenous Infu	January 2013	28	ACRh, ASCO, AS
96367	Intravenous infusion, fc	Intravenous Infu	January 2013	28	ACRh, ASCO, AS
96368	Intravenous infusion, fc	Intravenous Infu	January 2013	28	ACRh, ASCO, AS
96372	Therapeutic, prophylac	Application of C	January 2017	26	ASCO, ASH, AAF
96374	Therapeutic, prophylac	Application of C	January 2017	26	ASCO, ASH, ACR
96375	Therapeutic, prophylac	Application of C	January 2017	26	ASCO, ASH, ACR
96377	Application of on-body	Application of C	January 2017	26	ASCO, ASH
96401	Chemotherapy adminis	Chemotherapy .	January 2017	27	ASBMT, ASCO, A
96402	Chemotherapy adminis	Chemotherapy .	January 2017	27	ASBMT, ASCO, A
96405	Chemotherapy adminis	Chemotherapy .	April 2008	55	ASCO
96406	Chemotherapy adminis	Chemotherapy .	April 2008	55	ASCO
96409	Chemotherapy adminis	Chemotherapy .	January 2017	27	ASBMT, ASCO, A
96411	Chemotherapy adminis	Chemotherapy .	January 2017	27	ASBMT, ASCO, A
96413	Chemotherapy adminis	Chemotherapy .	January 2013	29	ACRh, ASCO, AS
96415	Chemotherapy adminis	Chemotherapy .	January 2013	29	ACRh, ASCO, AS
96416	Chemotherapy adminis	Chemotherapy .	October 2010	20	ACRh, ASCO, AS
96417	Chemotherapy adminis	Chemotherapy .	January 2013	29	ACRh, ASCO, AS
96440	Chemotherapy adminis	Chemotherapy .	February 2008	R	
96567	Photodynamic therapy	Photodynamic T	January 2017	16	AAD
96573	Photodynamic therapy	Photodynamic T	January 2017	16	AAD
96574	Debridement of premal	Photodynamic T	January 2017	16	AAD
96910	Photochemotherapy; ta	Photo-chemoth	April 2016	44	AAD

96920	Laser treatment for infl	Laser Treatmen	October 2019	17	October 2021	RAW	AAD
96921	Laser treatment for infl	Laser Treatmen	October 2019	17	October 2021	RAW	AAD
96922	Laser treatment for infl	Laser Treatmen	October 2019	17	October 2021	RAW	AAD
97001	Physical therapy evalua	Physical Medici	October 2015	17		HCPAC	
97002	Physical therapy re-eva	Physical Medici	October 2015	17		HCPAC	
97003	Occupational therapy e	Physical Medici	October 2015	17		HCPAC	
97004	Occupational therapy r	Physical Medici	October 2015	17		HCPAC	
97010	Application of a modali	Physical Medici	April 2017	41			No Interest
97012	Application of a modali	Physical Medici	January 2017	29			APTA
97014	Application of a modali	Physical Medici	January 2017	29			APTA
97016	Application of a modali	Physical Medici	January 2017	29			APTA
97018	Application of a modali	Physical Medici	January 2017	29			AOTA, APTA
97022	Application of a modali	Physical Medici	January 2017	29			APTA
97032	Application of a modali	Physical Medici	January 2017	29			APTA
97033	Application of a modali	Physical Medici	January 2017	29			APTA
97034	Application of a modali	Physical Medici	January 2017	29			APTA, AOTA
97035	Application of a modali	Physical Medici	January 2017	29			APTA
97110	Therapeutic procedure,	Physical Medici	January 2017	29			AOTA, APTA
97112	Therapeutic procedure,	Physical Medici	January 2017	29			APTA, AOTA
97113	Therapeutic procedure,	Physical Medici	January 2017	29			APTA
97116	Therapeutic procedure,	Physical Medici	January 2017	29			APTA
97127	Therapeutic interventic	Cognitive Funct	January 2017	29			
97140	Manual therapy techni	Physical Medici	January 2017	29			APTA
97150	Therapeutic procedure(	Physical Medici	January 2012				APTA
97161	Physical therapy evalua	Physical Medici	October 2015	17		HCPAC	AOTA, APTA
97162	Physical therapy evalua	Physical Medici	October 2015	17		HCPAC	AOTA, APTA
97163	Physical therapy evalua	Physical Medici	October 2015	17		HCPAC	AOTA, APTA
97164	Re-evaluation of physic	Physical Medici	October 2015	17		HCPAC	AOTA, APTA
97165	Occupational therapy e	Physical Medici	October 2015	17		HCPAC	AOTA, APTA
97166	Occupational therapy e	Physical Medici	October 2015	17		HCPAC	AOTA, APTA
97167	Occupational therapy e	Physical Medici	October 2015	17		HCPAC	AOTA, APTA
97168	Re-evaluation of occup	Physical Medici	October 2015	17		HCPAC	AOTA, APTA
97530	Therapeutic activities, c	Physical Medici	January 2017	29			APTA, AOTA
97532	Development of cogniti	Cognitive Funct	January 2017	29			APTA, AOTA, AS
97533	Sensory integrative tecl	Physical Medici	January 2017	29			APTA, AOTA
97535	Self-care/home manage	Physical Medici	January 2017	29			APTA, AOTA
97537	Community/work reinte	Physical Medici	January 2017	29			APTA, AOTA
97542	Wheelchair manageme	Physical Medici	January 2017	29			APTA, AOTA
97597	Debridement (eg, high p	Open Wound D	October 2018	23			AAFP, ACS, APM
97598	Debridement (eg, high p	Open Wound D	October 2018	23			AAFP, ACS, APM
97602	Removal of devitalized	Physical Medici	April 2016	47			AAOS, ACS, APM
97605	Negative pressure wou	Negative Pressu	April 2016	47			AAOS, ACS, APM
97606	Negative pressure wou	Negative Pressu	April 2016	47			APMA, ACS, AA
97607	Negative pressure wou	Negative Pressu	April 2016	47			APMA, ACS, AA
97608	Negative pressure wou	Negative Pressu	April 2016	47			APMA, ACS, AA
97610	Low frequency, non-co	Physical Medici	April 2016	47			
97755	Assistive technology as	Physical Medici	April 2016	47			APTA, AOTA

97760	Orthotic(s) managemer	Orthotic Manag	January 2017	29			APTA, AOTA
97761	Prosthetic(s) training, u	Orthotic Manag	January 2017	29			APTA
97762	Checkout for orthotic/p	Orthotic Manag	January 2017	29			APTA
97763	Orthotic(s)/prosthetic(s	Orthotic Manag	January 2017	29			APTA, AOTA
97802	Medical nutrition thera	Medical Nutritic	April 2008	53			ADA, AGA, AAC
97803	Medical nutrition thera	Medical Nutritic	April 2008	53			ADA, AGA, AAC
98925	Osteopathic manipulati	Osteopathic Ma	February 2011	34			AOA
98926	Osteopathic manipulati	Osteopathic Ma	February 2011	34			AOA
98927	Osteopathic manipulati	Osteopathic Ma	February 2011	34			AOA
98928	Osteopathic manipulati	Osteopathic Ma	February 2011	34			AOA
98929	Osteopathic manipulati	Osteopathic Ma	February 2011	34			AOA
98940	Chiropractic manipulati	Chiropractic Ma	October 2012	25			ACA
98941	Chiropractic manipulati	Chiropractic Ma	October 2012	25			ACA
98942	Chiropractic manipulati	Chiropractic Ma	October 2012	25			ACA
98943	Chiropractic manipulati	Chiropractic Ma	October 2012	25			ACA
99143	Deleted from CPT	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99144	Deleted from CPT	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99148	Deleted from CPT	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99149	Deleted from CPT	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99150	Deleted from CPT	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99151	Moderate sedation ser	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99152	Moderate sedation ser	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99155	Moderate sedation ser	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99156	Moderate sedation ser	Moderate Seda	October 2015	14		RUC	AAP, AAOMS, A
99174	Instrument-based ocula	Instrument-Bas	September 201	09			AAP, AAO
99177	Instrument-based ocula	Instrument-Bas	September 201	09			
99183	Physician or other quali	Hyperbaric Oxy	January 2014	33			ACEP, ACP, ACS
99281	Emergency department	ED Visits	April 2018	29			AAP, ACEP
99282	Emergency department	ED Visits	April 2018	29			AAP, ACEP
99283	Emergency department	ED Visits	April 2018	29			AAP, ACEP
99284	Emergency department	ED Visits	April 2018	29			AAP, ACEP
99285	Emergency department	ED Visits	April 2018	29			AAP, ACEP
99358	Prolonged evaluation a	Prolonged Servi	October 2020	12	April 2021	RUC	AAAAI, AACAP,
99359	Prolonged evaluation a	Prolonged Servi	October 2020	12	April 2021	RUC	AAAAI, AACAP,
99363	Anticoagulant manager	Home INR Mon	January 2017	19			
99364	Anticoagulant manager	Home INR Mon	January 2017	19			
99375	Supervision of a patient	Home Healthca	April 2016	47			No Interest
99378	Supervision of a hospic	Home Healthca	April 2016	47			No Interest
99491	Chronic care managem	Chronic Care M	April 2017	09			AAFP, AAN, ACP
99492	Initial psychiatric collab	Psychiatric Colla	January 2020	37	October 2022	RAW	AACAP, AAFP, A
99493	Subsequent psychiatric	Psychiatric Colla	January 2020	37	October 2022	RAW	AACAP, AAFP, A
99494	Initial or subsequent ps	Psychiatric Colla	January 2020	37	October 2022	RAW	AACAP, AAFP, A
99497	Advance care planning	Advance Care P	October 2019	17	October 2021	RAW	AAFP, AAN, ACP
99498	Advance care planning	Advance Care P	October 2019	17	October 2021	RAW	AAFP, AAN, ACP
G0101	Cervical or vaginal cancer screening; pe		October 2016	35			ACOG
G0102	Prostate cancer screeni	RAW	January 2017	30			
G0104	Colorectal cancer scree	Flexible Sigmoi	January 2014	09			AGA, ASGE, ACG

G0105	Colorectal cancer scree	Colonoscopy	January 2014	10			AGA, ASGE, ACG
G0108	Diabetes outpatient sel	Diabetes Mana	April 2017	41iv			AND
G0109	Diabetes outpatient sel	Diabetes Mana	April 2017	41iv			AND
G0121	Colorectal cancer scree	Colonoscopy	January 2014	10			AGA, ASGE, ACG
G0124	Screening cytopatholog	Cytopathology (	April 2018	26			CAP
G0127	Trimming of dystrophic nails, any numb		September 201	51			APMA
G0141	Screening cytopatholog	Cytopathology (	April 2018	26			CAP
G0166	External counterpulsati	External Counte	October 2019	14			ACC
G0168	Wound closure utilizing	Wound Closure	April 2017	34			ACEP, AAFP
G0179	Physician re-certificatio	Physician Recer	April 2016	47			No Interest
G0180	Physician certification f	Physician Recer	April 2016	47			No Interest
G0181	Physician supervision o	Home Healthca	April 2016	47			No Interest
G0182	Physician supervision o	Home Healthca	April 2016	47			No Interest
G0202	Screening mammograp	Mammography	January 2016	20			ACR
G0204	Diagnostic mammograp	Mammography	January 2016	20			ACR
G0206	Diagnostic mammograp	Mammography	January 2016	20			ACR
G0237	Therapeutic procedures	Respiratory The	February 2009	38			ACCP/ATS
G0238	Therapeutic procedures	Respiratory The	February 2009	38			ACCP/ATS
G0248	Demonstration, prior to	Home INR Mon	January 2017	19			ACC
G0249	Provision of test materi	Home INR Mon	January 2017	19			ACC
G0250	Physician review, interp	Home INR Mon	January 2017	19			ACC
G0268	Removal of impacted c	Removal of Imp	April 2017	35			AAO-HNS
G0270	Medical nutrition thera	Medical Nutritic	January 2019	37			ADA
G0279	Diagnostic digital breas	RAW	January 2018	31			
G0283	Electrical stimulation (u	Physical Medici	January 2017	29			APTA
G0296	Counseling visit to disc	RAW	October 2019	17	October 2021	RAW	
G0297	Low dose ct scan (ldct)	Screening CT of	October 2019	07			
G0364	Bone marrow aspiratio	RAW	January 2018	31			
G0365	Vessel mapping of vess	Duplex Scan Art	January 2019	17			ACR, SIR, SVS
G0389	Ultrasound b-scan and/	Abdominal Aort	October 2015	12			ACC, ACP, ACR,
G0396	Alcohol and/or substance (other than to		January 2018	31			AAFP, ASA, ASA
G0399	Home sleep test (hst) with type iii porta		January 2019	37			
G0402	Initial preventive physic	Initial Preventiv	October 2016	35			No Specialty So
G0403	Electrocardiogram, rou	EKG for Initial P	October 2016	35			No Specialty So
G0407	Follow-up inpatient consultation, interr		January 2021	29	April 2021	RAW	
G0408	Follow-up inpatient consultation, comp		January 2021	29	April 2021	RAW	
G0416	Surgical pathology, gros	Prostate Biopsy	October 2015	16		RUC	ASC, CAP
G0422	Intensive cardiac rehabilitation; with or		January 2021	29			
G0423	Intensive cardiac rehabilitation; with or		January 2021	29			
G0436	Smoking and tobacco c	RAW	October 2016	35		RUC	
G0438	Annual wellness visit; ir	RAW	April 2016	47			No Interest
G0439	Annual wellness visit, ir	RAW	April 2016	47			No Interest
G0442	Annual alcohol misuse s	Annual Alcohol	October 2016	35			No Specialty So
G0444	Annual depression scre	Annual Depress	October 2016	35			No Specialty So
G0446	Annual, face-to-face int	Intensive Behav	January 2018				No Specialty So
G0447	Face-to-face behavioral	Behavioral Cour	October 2016	35			No Specialty So
G0452	Molecular pathology pr	Molecular Path	October 2019	13			

G0453	Continuous intraoperat	RAW	October 2016	35			
G0456	Negative pressure wou	Negative Pressu	January 2014	17			
G0457	Negative pressure wou	Negative Pressu	January 2014	17			
G0500	Moderate sedation services provided b		January 2021	29			
G0506	Comprehensive assessment of and care		January 2021	29	October 2021	RAW	
G6001	Ultrasonic guidance for placement of ra		January 2021	29	January 2022	RUC	
G6002	Stereoscopic x-ray guidance for localiza		January 2018	31			
G6012	Radiation treatment delivery,3 or more		January 2021	29	October 2023	RAW	
G6013	Radiation treatment delivery,3 or more		January 2021	29	October 2023	RAW	
G6014	Radiation treatment de	RAW	October 2019	17			
G6015	Intensity modulated treatment delivery		January 2021	29	October 2023	RAW	
G6017	Intra-fraction localization and tracking c		January 2021	29	October 2023	RAW	
GPCX1	Visit complexity inhere	Visit Complexity	January 2020	34			
P3001	Screening papanicolaou	Cytopathology (	April 2018	26			CAP
Q0091	Screening papanicolaou	RAW	January 2019	37			No Specialty So

RUC Recommendation	Screen	First Identified - RUC Meeting Date	Global	2021 work RVU	2021 Non-Fac PE RVU
Remove from screen	High Volume Growth5	October 2018	XXX	0	0.00
12	High Volume Growth4	October 2016	XXX	0	0.00
Remove from screen	High Volume Growth5	October 2018	XXX	0	0.00
5 base units	CMS Request - Final Rule for 2016	September 2016	XXX	0	0.00
6 base units	CMS Request - Final Rule for 2016	September 2016	XXX	0	0.00
Deleted from CPT	CMS Request - Final Rule for 2016	July 2015			
Deleted from CPT	CMS Request - Final Rule for 2016	July 2015			
4 base units	CMS Request - Final Rule for 2016	September 2016	XXX	0	0.00
3 base units	CMS Request - Final Rule for 2016	September 2016	XXX	0	0.00
5 base units	CMS Request - Final Rule for 2016	September 2016	XXX	0	0.00
Maintain	High Volume Growth7	October 2020	XXX	0	0.00
Review action plan	High Volume Growth6	October 2019	XXX	0	0.00
Deleted from CPT	High Volume Category III Codes	October 2019	XXX	0	0.00
Remove from screen	High Volume Growth1	February 2008	XXX	0	0.00
Deleted from CPT	High Volume Growth4	January 2021	XXX	0	0.00
Deleted from CPT	High Volume Growth4	October 2016	XXX	0	0.00
4	High Volume Growth4	January 2021			
4	High Volume Growth4	January 2021			
4	High Volume Growth4	January 2021			
4	High Volume Growth4	January 2021			
6	High Volume Growth4	January 2021			
6	High Volume Growth4	January 2021			
Maintain	High Volume Category III Codes	October 2019	YYY	0	0.00
Deleted from CPT	High Volume Category III Codes	October 2019	XXX	0	0.00
Review in 3 years (Oct 20	High Volume Category III Codes	October 2019	XXX	0	0.00
Review in 3 years (Oct 20	High Volume Category III Codes	October 2019	XXX	0	0.00
Refer to CPT time uncerta	CMS Request - Final Rule for 2020	November 2019	YYY	1.14	53.70
Refer to CPT time uncerta	CMS Request - Final Rule for 2020	November 2019	YYY	1.34	1.55
Refer to CPT time uncerta	CMS Request - Final Rule for 2020	November 2019	YYY	1.91	53.16
Maintain	High Volume Category III Codes	October 2019	YYY	0	0.00
Maintain	High Volume Category III Codes	October 2019	XXX	0	0.00
Review action plan	Work Neutrality 2019	October 2020	XXX	0.4	1.84
Contractor Price	High Volume Category III Codes	January 2021			
0.80	CMS High Expenditure Procedural C	June 2017	ZZZ	0.8	0.59
1.63	CMS High Expenditure Procedural C	June 2017	XXX	1.46	2.38
1.00	CMS High Expenditure Procedural C	June 2017	ZZZ	1	0.67
1.81	CMS High Expenditure Procedural C	June 2017	XXX	1.81	7.06
1.18	CMS High Expenditure Procedural C	June 2017	ZZZ	1.18	3.52
2.43	CMS High Expenditure Procedural C	June 2017	XXX	2.26	11.44
1.65	CMS High Expenditure Procedural C	June 2017	ZZZ	1.65	6.42
Contractor Price	CMS High Expenditure Procedural C	June 2017	XXX	0	0.00
Contractor Price	CMS High Expenditure Procedural C	June 2017	ZZZ	0	0.00
1.20	CMS Request - Final Rule for 2016 /	July 2015	XXX	1.03	1.85
Deleted from CPT	CMS Fastest Growing / CMS High E	October 2008			

3.00	Codes Reported Together 75% or M	January 2012	000	2.75	16.52
0.91	Harvard Valued - Utilization over 3(	October 2015	010	0.91	2.42
1.50	Harvard Valued - Utilization over 1(	February 2010	010	1.22	2.27
Maintain. 2.45	Harvard Valued - Utilization over 1(	October 2009	010	2.45	3.45
1.25	Harvard Valued - Utilization over 3(	April 2011	010	1.22	3.14
Remove from re-review	RUC identified when reviewing com	January 2013	010	2.3	4.99
Deleted from CPT	Site of Service Anomaly	September 2007			
Deleted from CPT	Site of Service Anomaly	September 2007			
1.12	Site of Service Anomaly	September 2007	000	1.01	2.68
3.00	Site of Service Anomaly	September 2007	000	2.7	3.78
4.56	Site of Service Anomaly	September 2007	000	4.1	4.42
0.69	Site of Service Anomaly	February 2010	ZZZ	0.5	0.62
1.29	Site of Service Anomaly	February 2010	ZZZ	1.03	0.94
2.00	Site of Service Anomaly / High Volu	February 2010	ZZZ	1.8	1.44
Maintain	CMS Request to Re-Review Familie:	November 2011	000	0.35	1.66
0.50	MPC List / CMS Request to Re-Revi	October 2010	000	0.5	1.81
Maintain	CMS Request to Re-Review Familie:	November 2011	000	0.65	1.88
Deleted from CPT	MPC List / CMS High Expenditure P	October 2010			
Deleted from CPT	Low Value Billed in Multiple Units /	October 2010			
0.66	CMS High Expenditure Procedural (	February 2017	000	0.66	2.34
0.38	CMS High Expenditure Procedural (	February 2017	ZZZ	0.38	1.13
0.83	CMS High Expenditure Procedural (	February 2017	000	0.83	2.90
0.45	CMS High Expenditure Procedural (	February 2017	ZZZ	0.45	1.29
1.01	CMS High Expenditure Procedural (	February 2017	000	1.01	3.55
0.54	CMS High Expenditure Procedural (	February 2017	ZZZ	0.54	1.55
0.60	CMS High Expenditure Procedural (	January 2012	000	0.6	2.38
0.90	CMS High Expenditure Procedural (	January 2012	000	0.9	2.67
1.16	CMS High Expenditure Procedural (	January 2012	000	1.05	3.02
1.25	CMS High Expenditure Procedural (	January 2012	000	1.25	3.22
0.80	CMS High Expenditure Procedural (	January 2012	000	0.8	2.32
1.18	CMS High Expenditure Procedural (	January 2012	000	0.96	2.63
1.20	CMS High Expenditure Procedural (	January 2012	000	1.2	2.95
1.46	CMS High Expenditure Procedural (	January 2012	000	1.46	2.93
1.19	CMS High Expenditure Procedural (	January 2012	000	0.8	2.60
1.43	CMS High Expenditure Procedural (	January 2012	000	1.1	2.89
1.80	CMS High Expenditure Procedural (	January 2012	000	1.3	3.26
2.00	CMS High Expenditure Procedural (	January 2012	000	1.68	3.60
0.17	Low Value-High Volume	October 2010	000	0.17	0.23
0.32 (Interim)	MPC List	Septemer 2011	000	0.32	0.61
0.54 (Interim)	MPC List	October 2010	000	0.54	0.72
1.10	CMS High Expenditure Procedural (	July 2015	000	1.05	2.29
1.99	010-Day Global Post-Operative Visi	January 2014	010	1.58	3.06
Deleted from CPT	010-Day Global Post-Operative Visi	January 2014			
1.25	CMS 000-Day Global Typically Repo	July 2016	000	1.25	2.38
0.52	Harvard Valued - Utilization over 1(	October 2009	000	0.52	1.08
0.80	Harvard Valued - Utilization over 1(	February 2010	000	0.8	1.17
1.10	High Volume Growth2 / Different P	April 2013	000	1.1	1.54

1.30	High Volume Growth1 / Different P	June 2008	000	1.14	1.70
1.70	High Volume Growth1 / Different P	February 2008	000	1.34	1.85
2.10	High Volume Growth1	June 2008	000	1.91	2.03
0.84	Harvard Valued - Utilization over 1(	October 2009	000	0.84	1.77
1.14	Harvard Valued - Utilization over 1(	October 2009	000	1.14	1.99
1.44	Harvard Valued - Utilization over 1(	April 2010	000	1.44	2.18
1.97	Harvard Valued - Utilization over 1(	April 2010	000	1.97	2.84
2.39	Harvard Valued - Utilization over 1(	April 2010	000	2.39	3.22
2.90	Harvard Valued - Utilization over 1(	April 2010	000	2.9	3.42
1.07	Harvard Valued - Utilization over 1(	April 2010	000	1.07	2.06
1.22	Harvard Valued - Utilization over 1(	April 2010	000	1.22	2.02
1.57	Harvard Valued - Utilization over 1(	April 2010	000	1.57	2.37
1.98	Harvard Valued - Utilization over 1(	April 2010	000	1.98	2.74
2.68	Harvard Valued - Utilization over 1(	April 2010	000	2.68	3.30
3.18	Harvard Valued - Utilization over 1(	April 2010	000	3.18	NA
3.61	Harvard Valued - Utilization over 1(	April 2010	000	3.61	NA
2.00	Harvard Valued - Utilization over 1(	February 2010	010	2	5.54
2.52	Harvard Valued - Utilization over 1(	October 2009	010	2.52	6.28
2.97	Harvard Valued - Utilization over 1(	February 2010	010	2.97	6.53
3.60	Harvard Valued - Utilization over 1(	February 2010	010	3.5	7.58
4.50	Harvard Valued - Utilization over 1(	February 2010	010	4.23	7.86
5.25	Harvard Valued - Utilization over 1(	February 2010	010	5	8.45
2.10	Harvard Valued - Utilization over 1(	February 2010	010	2.1	5.46
2.79	Harvard Valued - Utilization over 1(	February 2010	010	2.79	6.05
3.19	Harvard Valued - Utilization over 1(	February 2010	010	3.19	7.68
3.90	Harvard Valued - Utilization over 1(	February 2010	010	3.75	7.69
4.60	Harvard Valued - Utilization over 1(	February 2010	010	4.3	9.67
5.50	Harvard Valued - Utilization over 1(	February 2010	010	4.95	10.26
2.33	Harvard Valued - Utilization over 1(	February 2010	010	2.33	5.76
Remove from screen	Harvard Valued - Utilization over 1(	February 2010	010	2.87	6.10
3.17	Harvard Valued - Utilization over 1(	February 2010	010	3.17	7.28
3.50	Harvard Valued - Utilization over 1(	February 2010	010	3.5	7.45
4.65	Harvard Valued - Utilization over 1(	February 2010	010	4.5	9.72
5.50	Harvard Valued - Utilization over 1(	February 2010	010	5.3	11.05
6.28	Harvard Valued - Utilization over 1(	February 2010	010	6	11.25
3.00	CMS Request	July 2011	010	3	6.88
3.50	CMS Request	July 2011	010	3.5	8.05
1.24	CMS Request	July 2011	ZZZ	1.24	2.09
3.23	CMS Fastest Growing / CPT Assistar	October 2008	010	3.23	7.04
4.00	CMS Fastest Growing / CPT Assistar	October 2008	010	4	8.34
1.44	CMS Fastest Growing / CPT Assistar	October 2008	ZZZ	1.44	2.18
3.73	Harvard Valued - Utilization over 3(	April 2011	010	3.73	7.46
4.78	CMS Request	September 2011	010	4.78	8.81
2.19	CMS Request	September 2011	ZZZ	2.19	2.58
Deleted from CPT	CMS Request	September 2011			
4.34	CMS Request	September 2011	010	4.34	7.79
5.34	Harvard Valued - Utilization over 3(	April 2011	010	5.34	8.93

2.38	CMS Request	July 2011	ZZZ	2.38	2.80
6.19	Site of Service Anomaly	April 2008	090	6.37	11.17
8.58	Site of Service Anomaly	September 2007	090	8.78	13.39
7.02	Site of Service Anomaly	April 2008	090	7.22	12.29
9.52	Site of Service Anomaly / CMS Fast	September 2007	090	9.72	14.29
8.44	Site of Service Anomaly	April 2008	090	8.6	12.51
10.63	Site of Service Anomaly	September 2007	090	10.83	14.84
Maintain	Site of Service Anomaly	April 2008	090	9.23	12.12
11.25	Site of Service Anomaly	September 2007	090	11.48	16.18
Deleted from CPT	Site of Service Anomaly / CMS Fast	September 2007			
12.47	Site of Service Anomaly / CMS Fast	September 2007	090	12.65	17.28
3.73	Site of Service Anomaly / CMS Fast	September 2007	ZZZ	3.73	1.96
Maintain work RVU and a	Pre-Time Analysis	January 2014	000	3.65	6.16
Maintain work RVU and a	Pre-Time Analysis	January 2014	000	4.58	6.61
Maintain work RVU and a	Pre-Time Analysis	January 2014	090	9.9	13.91
Remove from screen	Site of Service Anomaly	September 2007	090	10.15	13.24
Deleted from CPT	Different Performing Specialty from	February 2010			
Deleted from CPT	Different Performing Specialty from	February 2010			
Deleted from CPT	Different Performing Specialty from	October 2009			
Deleted from CPT	Different Performing Specialty from	February 2010			
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	8.09	13.42
Maintain work RVU and a	Pre-Time Analysis	January 2014	090	10.41	15.47
1.50	Different Performing Specialty from	April 2011	000	1.5	2.83
0.59	Different Performing Specialty from	April 2011	ZZZ	0.33	0.36
3.50	Different Performing Specialty from	April 2011	000	3.5	5.22
0.80	Different Performing Specialty from	April 2011	ZZZ	0.8	1.48
1.83	Different Performing Specialty from	April 2011	000	1.83	2.68
0.59	Different Performing Specialty from	April 2011	ZZZ	0.5	0.40
4.00	Different Performing Specialty from	April 2011	000	4	5.53
1.00	Different Performing Specialty from	April 2011	ZZZ	1	1.65
Deleted from CPT	Different Performing Specialty from	October 2009			
Deleted from CPT	Different Performing Specialty from	February 2010			
Deleted from CPT	High IWPUT	February 2008			
Deleted from CPT	Different Performing Specialty from	February 2010			
Deleted from CPT	Different Performing Specialty from	October 2009			
Deleted from CPT	Different Performing Specialty from	February 2010			
Deleted from CPT	Different Performing Specialty from	February 2010			
Deleted from CPT	Different Performing Specialty from	February 2010			
Deleted from CPT	Different Performing Specialty from	October 2009			
Deleted from CPT	Different Performing Specialty from	February 2010			
Deleted from CPT	Site of Service Anomaly	September 2007			
Deleted from CPT	High Volume Growth1	February 2008			
Deleted from CPT	Different Performing Specialty from	October 2009			
Deleted from CPT	Different Performing Specialty from	February 2010			
10.00	Site of Service Anomaly	September 2007	090	10.21	14.85
9.94	Site of Service Anomaly	April 2008	090	10.12	14.00
10.52	Site of Service Anomaly	September 2007	090	10.7	13.68

9.24	Site of Service Anomaly	September 2007	090	9.37	12.76
13.50	High Level E/M in Global Period	January 2017	090	13.5	28.61
Not part of family	High Level E/M in Global Period	April 2016	090	14.38	16.41
Deleted from CPT	Site of Service Anomaly / High Leve	September 2007			
15.68	High Level E/M in Global Period	January 2017	090	15.68	NA
23.00	High Level E/M in Global Period	October 2015	090	23	NA
17.04	High Level E/M in Global Period	January 2016	090	17.04	NA
19.04	High Level E/M in Global Period	January 2016	090	19.04	NA
11.57	Site of Service Anomaly / CMS Fast	September 2007	090	11.8	15.93
6.68. Flagged for RAW re	Site of Service Anomaly - 2017	May 2018	090	6.68	NA
6.73	Site of Service Anomaly - 2017	May 2018	090	6.73	8.97
2.50	Site of Service Anomaly - 2017	May 2018	ZZZ	2.5	2.34
6.83	Site of Service Anomaly - 2017	May 2018	090	6.83	9.01
2.41	Site of Service Anomaly - 2017	May 2018	ZZZ	2.41	2.30
3.65	Different Performing Specialty from	April 2011	ZZZ	3.65	1.97
6.81	Harvard Valued - Utilization over 1(	October 2009	090	6.81	10.71
0.80	Different Performing Specialty from	October 2009	000	0.71	1.66
1.85	Different Performing Specialty from	October 2009	000	1.74	2.58
CPT Assistant article publ	Different Performing Specialty from	February 2010	000	2.08	3.28
0.61	MPC List	October 2010	010	0.61	1.27
0.04	Low Value-Billed in Multiple Units /	October 2010	ZZZ	0.04	0.15
Remove from Modifier -5	CMS High Expenditure Procedural (	September 2011	010	1.37	3.35
3.61	High IWPUT	February 2008	090	3.69	5.92
4.68	High IWPUT	February 2008	090	4.79	7.74
6.37	High IWPUT	February 2008	090	7.49	10.10
Remove from screen	High Volume Growth2	April 2013	010	0.7	2.57
Remove from screen	High Volume Growth2	April 2013	010	0.97	2.84
Review in 2 years (Oct 20	High Volume Growth3	October 2015	000	0.5	2.07
1.22	Harvard Valued - Utilization over 1(	October 2009	010	1.22	3.00
1.63	Harvard Valued - Utilization over 1(	February 2010	010	1.63	3.45
1.54	Harvard Valued - Utilization over 1(	February 2010	010	1.54	3.18
1.82	Harvard Valued - Utilization over 1(	February 2010	010	1.82	3.54
1.77	Harvard Valued - Utilization over 1(	February 2010	010	1.77	3.33
2.09	Harvard Valued - Utilization over 1(	October 2009	010	2.09	3.74
6.20	CMS High Expenditure Procedural (	September 2011	000	6.2	12.99
3.30	CMS High Expenditure Procedural (	September 2011	ZZZ	3.3	8.41
5.56	CMS High Expenditure Procedural (	January 2012	000	5.56	12.49
3.06	CMS High Expenditure Procedural (	January 2012	ZZZ	3.06	8.16
0.87	CMS High Expenditure Procedural (	January 2012	ZZZ	0.87	1.30
Reduce 99238 to 0.5, rem	Site of Service Anomaly	September 2007	090	3.83	9.57
3.29	Codes Reported Together 75% or M	January 2012	000	3.29	13.26
1.65	Codes Reported Together 75% or M	January 2012	ZZZ	1.65	11.70
3.10	Codes Reported Together 75% or M	January 2012	000	3.1	13.47
1.55	Codes Reported Together 75% or M	January 2012	ZZZ	1.55	11.57
3.64	Codes Reported Together 75% or M	January 2012	000	3.64	22.01
1.82	Codes Reported Together 75% or M	January 2012	ZZZ	1.82	18.59
Deleted from CPT	Codes Reported Together 75% or M	January 2012			

Deleted from CPT	Codes Reported Together 75% or M	January 2012			
2.00	Codes Reported Together 75% or M	January 2012	000	2	5.08
1.00	Codes Reported Together 75% or M	January 2012	ZZZ	1	4.08
2.00	Codes Reported Together 75% or M	January 2012	000	2	5.80
1.00	Codes Reported Together 75% or M	January 2012	ZZZ	1	4.98
1.70	Codes Reported Together 75% or M	January 2012	000	1.7	10.83
0.85	Codes Reported Together 75% or M	January 2012	ZZZ	0.85	9.77
3.02	Codes Reported Together 75% or M	January 2012	000	2.55	19.02
1.51	Codes Reported Together 75% or M	January 2012	ZZZ	1.28	15.82
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Deleted from CPT	CMS Fastest Growing / Codes Repo	October 2008			
15.00	Site of Service Anomaly - 2015 / Hig	October 2015	090	15	NA
17.99	Site of Service Anomaly - 2019	October 2019	090	17.99	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	16.03	NA
11.00	CMS Request / Site of Service Anon	October 2009	090	10.48	NA
15.36	Site of Service Anomaly / 090-Day G	September 2007	090	14.84	NA
Deleted from CPT	Site of Service Anomaly (99238-Onl	September 2007			
Deleted from CPT	Site of Service Anomaly / Negative	September 2007			
1.93	Different Performing Specialty from	January 2018	000	1.65	5.58
3.00	Different Performing Specialty from	October 2017	000	2.45	9.49
3.73	010-Day Global Post-Operative Visi	April 2014	000	2.61	NA
6.50	010-Day Global Post-Operative Visi	January 2014	000	6	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	010	3.54	10.08
Remove fromm screen	CMS 000-Day Global Typically Repo	July 2016	000	0.94	1.27
0.75	CMS Fastest Growing / CMS High Ex	October 2008	000	0.75	0.80
0.75	CMS Fastest Growing / CMS 000-Da	October 2008	000	0.75	0.84
0.66	CMS High Expenditure Procedural C	July 2015	000	0.66	0.84
0.75	CMS High Expenditure Procedural C	July 2015	000	0.75	0.98
0.66 and new PE inputs	Harvard Valued - Utilization over 10	February 2010	000	0.66	0.77
0.89	CMS Request - Final Rule for 2014	July 2013	000	0.89	1.38
0.68 and new PE inputs	Harvard Valued - Utilization over 10	October 2009	000	0.68	0.81
1.00	CMS Request - Final Rule for 2014	July 2013	000	1	1.47
0.79 and new PE inputs	Harvard Valued - Utilization over 10	February 2010	000	0.79	0.96
1.10	CMS Request - Final Rule for 2014	July 2013	000	1.1	1.65
Remove from screen	CMS 000-Day Global Typically Repo	July 2016	000	0.7	1.06
5.96 and adjustments to p	Pre-Time Analysis	January 2014	090	5.96	11.22
Maintain	090-Day Global Post-Operative Visi	January 2014	090	16.27	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	4.28	7.72
1.50	Different Performing Specialty from	May 2018	ZZZ	1.5	0.68
1.13	Different Performing Specialty from	May 2018	ZZZ	1.13	0.51
2.50	Different Performing Specialty from	May 2018	ZZZ	2.5	1.14
1.80	Different Performing Specialty from	May 2018	ZZZ	1.8	0.82
2.60	Different Performing Specialty from	May 2018	ZZZ	2.6	1.19
2.15	Different Performing Specialty from	May 2018	ZZZ	2.15	0.98
3.00	Site of Service Anomaly	September 2007	000	3	8.60
4.58	Site of Service Anomaly	April 2008	000	4.58	NA

Deleted from CPT	CMS Fastest Growing / Site of Servi	October 2008			
9.71	Site of Service Anomaly	September 2007	090	9.89	NA
10.03	Site of Service Anomaly	September 2007	090	10.03	12.52
Deleted from CPT	090-Day Global Post-Operative Visi	October 2015			
14.57	Site of Service Anomaly	September 2007	090	14.75	NA
Deleted from CPT	CMS Request - Final Rule for 2014	July 2013			
Deleted from CPT	CMS Request - Final Rule for 2014	January 2014			
Deleted from CPT	CMS Request - Final Rule for 2014	January 2014			
19.55	CMS Request - Final Rule for 2014	January 2014	000	10.79	NA
25.00	CMS Request - Final Rule for 2014	January 2014	000	13	NA
35.00	CMS Request - Final Rule for 2014	January 2014	000	17.61	NA
PE Clinical staff pre-time i	CMS Request - Final Rule for 2014 /	January 2014	090	1.36	2.76
Unrelated to the family	CMS Request - Final Rule for 2014	January 2014	090	7.76	NA
15.54	Site of Service Anomaly	September 2007	090	15.72	NA
Maintain	CMS Fastest Growing	October 2008	090	21.02	NA
Deleted from CPT	CMS Request - Final Rule for 2014	July 2013			
3.45. Flag for Rereview	Negative IWPUT / Site of Service Ar	April 2017	090	3.45	4.93
8.15	Codes Reported Together 75% or M	April 2014	010	7.9	47.52
8.05	Codes Reported Together 75% or M	April 2014	010	7.33	47.95
4.00	Codes Reported Together 75% or M	April 2014	ZZZ	4	19.83
8.90	Codes Reported Together 75% or M	April 2014	010	8.65	185.14
8.24	Codes Reported Together 75% or M	April 2014	010	7.99	185.16
4.00	Codes Reported Together 75% or M	April 2014	ZZZ	4	100.20
Deleted from CPT	CMS Request - Practice Expense Re	February 2009			
Deleted from CPT	Site of Service Anomaly (99238-Onl	September 2007			
Deleted from CPT	Codes Reported Together 75% or M	April 2014			
Deleted from CPT	CMS Request: PE Review	September 2011			
Deleted from CPT	CMS Request: PE Review	September 2011			
Deleted from CPT	CMS Request: PE Review	September 2011			
Remove from screen. CPT	CMS Fastest Growing	October 2008	090	24.79	NA
24.50	Codes Reported Together 95% or M	February 2010	090	25	NA
6.50	Codes Reported Together 95% or M	February 2010	ZZZ	6.5	NA
17.69	Codes Reported Together 95% or M	February 2008	090	17.69	NA
Review action plan and a	High Volume Growth2 / Codes Rep	April 2013	090	23.53	NA
Remove from screen	Codes Reported Together 95% or M	February 2010	ZZZ	5.52	NA
Review utilization data O	Codes Reported Together 75% or M	February 2010	090	23.53	NA
6.43	Codes Reported Together 75% or M	February 2010	ZZZ	6.43	NA
22.09	Codes Reported Together 75% or M	February 2010	090	22.09	NA
5.22	Codes Reported Together 75% or M	February 2010	ZZZ	5.22	NA
27.75	Codes Reported Together 75% or M	February 2010	090	27.75	NA
8.16	Codes Reported Together 75% or M	February 2010	ZZZ	8.16	NA
Remove from screen	CMS Fastest Growing	October 2008	ZZZ	13.44	NA
Maintain	CMS Fastest Growing	October 2008	090	19.17	NA
Deleted from CPT	CMS Fastest Growing / High Volum	October 2008			
6.00	CMS High Expenditure Procedural C	October 2015	ZZZ	5.5	NA
15.00	CMS High Expenditure Procedural C	October 2015	090	13.5	NA
5.50	CMS High Expenditure Procedural C	October 2015	ZZZ	4	NA

8.21	Site of Service Anomaly	September 2007	090	8.32	NA
7.28	Site of Service Anomaly	September 2007	090	7.41	NA
7.23	Site of Service Anomaly	September 2007	090	7.39	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	7.77	NA
1.00	Harvard Valued - Utilization over 3(	April 2011	000	1	3.80
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	8.54	NA
11.23	Site of Service Anomaly	September 2007	090	11.39	NA
Maintain work RVU and a	Site of Service Anomaly / Pre-Time	September 2007	090	11.93	NA
9.23	Site of Service Anomaly	September 2007	090	9.23	NA
13.35	Site of Service Anomaly	September 2007	090	13.54	NA
10.17	CMS Fastest Growing, Site of Servic	September 2007	090	10.17	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	10.64	NA
Remove from screen	CMS Fastest Growing / High Volum	October 2008	090	22.13	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	2.36	4.19
3.00	Harvard Valued - Utilization over 3(	April 2011	090	3	6.32
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	4.1	6.43
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	3.53	5.37
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	4.76	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	4.66	7.24
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	5.39	8.49
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	4.37	5.82
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	5.64	NA
7.56	Site of Service Anomaly	September 2007	090	7.56	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	6.12	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	8.04	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	7.39	NA
7.94	Site of Service Anomaly	September 2007	090	8.08	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	5.85	8.38
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	6.25	8.59
Maintain work RVU and a	Pre-Time Analysis	September 2014	090	8.31	NA
Maintain work RVU and a	Pre-Time Analysis	September 2014	090	9.56	NA
Maintain work RVU and a	Pre-Time Analysis	September 2014	090	11.07	NA
Maintain work RVU and a	Pre-Time Analysis	January 2014	090	14.38	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	4.89	7.39
7.79	Negative IWPUT	April 2017	090	6.84	NA
3.75	Negative IWPUT	April 2017	090	3.11	13.80
Action plan for RAW Oct 2	Site of Service Anomaly / CPT Assis	September 2007	090	4.47	NA
3.57	Negative IWPUT	April 2017	090	3.57	13.97
10.03	Site of Service Anomaly (99238-Onl	September 2007	090	9.56	NA
11.50	090-Day Global Post-Operative Visi	April 2014	090	11	NA
13.10	090-Day Global Post-Operative Visi	April 2014	090	12.6	NA
6.76	CMS Fastest Growing	October 2008	090	6.9	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	3.83	5.38
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	1.8	3.40
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	3.23	5.67
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	3.15	4.68
8.74	Site of Service Anomaly	September 2007	090	8.85	NA

5.66	Site of Service Anomaly	September 2007	090	5.75	NA
1.48	Different Performing Specialty from	October 2009	000	1.48	3.26
19.60	CMS High Expenditure Procedural C	September 2011	090	19.6	NA
Maintain work RVU and a	Pre-Time Analysis	January 2014	090	30.28	NA
Deleted from CPT	CMS Request - Final Rule for 2014	July 2013			
Deleted from CPT	CMS Request - Final Rule for 2014	October 2015			
5.50	CMS Request - Final Rule for 2014	October 2015	000	1.53	NA
9.00	CMS Request - Final Rule for 2014	October 2015	000	4.75	NA
6.00	Negative IWPUT	April 2017	090	5.5	5.78
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	5.81	7.43
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	11.72	NA
17.61	CMS High Expenditure Procedural C	September 2011	090	17.61	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	13.81	NA
18.00	High IWPUT	April 2008	090	18.18	NA
18.00	High IWPUT / CMS Fastest Growing	February 2008	090	18.18	NA
3.82	Site of Service Anomaly	September 2007	000	3.82	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	11.03	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	5.24	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	7.78	NA
9.03	CMS Request - Final Rule for 2018	July 2017	090	12.13	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	5.04	NA
0.96	Harvard Valued - Utilization Over 3(	June 2017	000	0.77	4.22
Deleted from CPT	High Volume Growth1 / CMS Faste:	February 2008			
17.48	CMS High Expenditure Procedural C	September 2011	090	17.48	NA
19.60	CMS High Expenditure Procedural C	September 2011	090	19.6	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	11.36	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	9.8	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	5.98	8.46
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	8.18	NA
15.54	Site of Service Anomaly	September 2007	090	15.72	NA
6.80	Site of Service Anomaly	September 2007	090	6.91	NA
12.10	Site of Service Anomaly	September 2007	090	12.24	NA
9.72	Site of Service Anomaly	February 2008	090	9.84	NA
9.00	Site of Service Anomaly	September 2007	090	9.21	NA
10.32	Site of Service Anomaly	September 2007	090	10.53	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	6.69	12.08
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	6.41	NA
8.96	Site of Service Anomaly	September 2007	090	9.17	NA
10.28	Site of Service Anomaly	September 2007	090	10.49	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	6.27	8.42
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	5.47	7.69
9.71	Site of Service Anomaly	June 2010	090	8.75	NA
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	5.32	7.64
Maintain work RVU and a	Pre-Time Analysis	January 2014	090	10.62	NA
PE Clinical staff pre-time i	Site of Service Anomaly (99238-Onl	September 2007	090	5.69	7.71
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	6.69	8.17
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	4.77	NA

2.00	010-Day Global Post-Operative Visi	April 2020	010	2.78	5.09
3.50	010-Day Global Post-Operative Visi	January 2014	010	5.34	7.01
5.28	010-Day Global Post-Operative Visi	April 2020	090	9.06	10.59
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	5.15	8.71
8.27	Site of Service Anomaly	September 2007	090	7.31	11.80
7.72	Site of Service Anomaly	September 2007	090	6.76	10.10
Remove 99238	Site of Service Anomaly (99238-Onl	September 2007	090	5	8.71
5.62	Harvard Valued - Utilization over 3(	February 2010	090	5.62	9.73
6.90	090-Day Global Post-Operative Visi	October 2015	090	6.9	13.18
Deleted from CPT	090-Day Global Post-Operative Visi	October 2015			
8.01	090-Day Global Post-Operative Visi	October 2015	090	8.01	12.74
7.44	090-Day Global Post-Operative Visi	October 2015	090	7.44	12.86
Deleted from CPT	090-Day Global Post-Operative Visi	January 2014			
Deleted from CPT	090-Day Global Post-Operative Visi	October 2015			
8.57	090-Day Global Post-Operative Visi	October 2015	090	8.57	23.38
8.25	Site of Service Anomaly	September 2007	090	8.25	17.86
9.29	090-Day Global Post-Operative Visi	October 2015	090	9.29	20.85
7.75	Site of Service Anomaly (99238-Onl	September 2007	090	7.75	16.46
9.29	090-Day Global Post-Operative Visi	October 2015	090	9.29	19.90
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	9.73	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	5.57	10.09
2.03	Harvard Valued - Utilization over 3(	April 2011	090	2.03	4.14
PE Clinical staff pre-time i	Emergent Procedures	October 2015	010	1.28	2.07
12.18	Site of Service Anomaly	September 2007	090	11.22	NA
12.42	Site of Service Anomaly	September 2007	090	10.7	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	9.29	14.18
4.10	Site of Service Anomaly - 2018	October 2018	090	3.51	5.16
4.00	Site of Service Anomaly	September 2007	090	3.41	5.09
0.77	Harvard Valued - Utilization over 3(	April 2011	000	0.77	1.62
0.80	CMS 000-Day Global Typically Repo	July 2016	000	0.8	1.45
0.39	High Volume Growth2	April 2013	000	0.39	0.56
Deleted from CPT	High Volume Growth1	February 2008			
0.39	High Volume Growth2	April 2013	000	0.39	0.49
0.39	High Volume Growth2	October 2013	000	0.39	0.45
0.39	High Volume Growth2	October 2013	000	0.39	0.43
1.78	High Volume Growth3	October 2015	000	1.78	1.78
0.39	High Volume Growth2	April 2013	000	0.39	0.64
0.39	High Volume Growth2	April 2013	000	0.39	0.48
0.39	Harvard Valued - Utilization over 1(	October 2009	000	0.39	0.39
0.25	Harvard Valued - Utilization over 1(	February 2010	000	0.25	0.28
0.55	CMS High Expenditure Procedural (	July 2015	000	0.55	1.26
0.60	CMS High Expenditure Procedural (	July 2015	000	0.6	2.03
Deleted from CPT	New Technology/New Services	October 2015			
Deleted from CPT	New Technology/New Services	October 2015			
Develop CPT Assistant Ar	New Technology/New Services	October 2015	000	0.35	2.12
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
No NF PE inputs	CMS Request - Practice Expense Re	NA	090	6.03	NA

7.03	CMS Fastest Growing	October 2008	090	7.03	NA
7.98	Harvard-Valued Annual Allowed Ch	October 2012	090	7.98	NA
8.82	Codes Reported Together 75% or M	February 2010	090	8.98	NA
3.00	Codes Reported Together 75% or M	February 2010	ZZZ	3	NA
15.59. Maintain work RVU	CMS Fastest Growing/ Codes Repor	October 2008	090	15.59	NA
13.16	Codes Reported Together 75% or M	February 2010	090	13.16	NA
No NF PE inputs	CMS Request - Practice Expense Re	NA	090	5.88	NA
No NF PE inputs	CMS Request - Practice Expense Re	NA	090	5.68	NA
New PE non-facility input	CMS Request - Practice Expense Re	NA	090	5.19	10.58
14.14	Site of Service Anomaly	September 2007	090	14.3	NA
No NF PE inputs	CMS Request - Practice Expense Re	NA	090	5.88	NA
3.00	Harvard Valued - Utilization over 3(	October 2015	000	3	5.28
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	12.36	NA
1.10	Harvard Valued - Utilization over 1(	October 2009	000	1.1	3.36
1.54	CMS Request - Final Rule for 2016	July 2015	000	1.54	5.49
1.97	CMS Request - Final Rule for 2016	July 2015	000	1.97	8.29
2.45	CMS Request - Final Rule for 2016	July 2015	000	2.45	8.13
1.10	MPC List	October 2010	000	1.1	4.54
2.60	CMS High Expenditure Procedural (	September 2011	000	2.6	4.56
2.74	CMS High Expenditure Procedural (	January 2012	000	2.74	4.25
9.04	CMS High Expenditure Procedural (	January 2012	010	9.04	NA
2.61	CMS High Expenditure Procedural (	January 2012	000	2.61	NA
8.51	Codes Reported Together 75% or M	April 2015	000	8	NA
9.00	Codes Reported Together 75% or M	April 2015	000	9	NA
4.27	CMS Request - Final Rule for 2016	July 2015	000	4.27	8.03
5.75	Codes Reported Together 75% or M	April 2015	000	5.75	NA
3.11	CMS Request - Final Rule for 2016	July 2015	000	3.11	NA
8.00	Codes Reported Together 75% or M	April 2015	000	8	NA
8.48	Codes Reported Together 75% or M	April 2015	000	8.48	NA
4.68	CMS Request - Final Rule for 2016	July 2015	000	4.68	NA
6.75	Codes Reported Together 75% or M	April 2015	000	6.75	NA
3.50	Codes Reported Together 75% or M	April 2015	000	3.5	NA
4.10	Codes Reported Together 75% or M	April 2015	000	4.1	NA
2.70	Codes Reported Together 75% or M	April 2015	000	2.7	52.30
3.10	Codes Reported Together 75% or M	April 2015	000	3.1	52.59
2.44	Codes Reported Together 75% or M	April 2015	000	2.44	52.17
4.50	Codes Reported Together 75% or M	April 2015	000	4.5	99.88
3.00	CMS High Expenditure Procedural (	July 2015	000	3	NA
21.50	090-Day Global Post-Operative Visi	October 2015	090	21.5	NA
20.50	090-Day Global Post-Operative Visi	October 2015	090	20.5	NA
22.00	090-Day Global Post-Operative Visi	October 2015	090	22	NA
22.00	090-Day Global Post-Operative Visi	October 2015	090	22	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	000	4.26	NA
1.00	MPC List / CMS High Expenditure P	October 2010	000	0.94	2.69
1.94	CMS Fastest Growing / CMS High E	October 2008	000	1.88	3.65
14.60	090-Day Global Post-Operative Visi	April 2014	090	14.6	NA
Deleted from CPT	090-Day Global Post-Operative Visi	April 2014			

20.00	090-Day Global Post-Operative Visi	April 2014	090	17.58	NA
15.27	090-Day Global Post-Operative Visi	April 2014	090	15.27	NA
Deleted from CPT	090-Day Global Post-Operative Visi	January 2014			
15.60	090-Day Global Post-Operative Visi	October 2015	090	13.56	NA
25.00	090-Day Global Post-Operative Visi	October 2015	090	25	NA
5.56	CMS High Expenditure Procedural C	July 2015	000	5.56	NA
8.00	CMS High Expenditure Procedural C	July 2015	000	8	NA
6.00	CMS High Expenditure Procedural C	July 2015	000	6	NA
6.45	CMS High Expenditure Procedural C	July 2015	000	6.45	NA
12.00	CMS High Expenditure Procedural C	July 2015	090	12	NA
Reduce 99238 to 0.5	Site of Service Anomaly	September 2007	090	6	NA
Deleted from CPT	High Volume Growth2	April 2013			
2.78	High Volume Growth2	April 2013	000	2.53	4.51
2.63	High Volume Growth4	October 2016	000	2.63	5.36
2.63	High Volume Growth4	October 2017	000	2.63	4.74
3.36	High Volume Growth2	April 2013	000	3.11	7.16
4.16	High Volume Growth2	April 2013	000	3.91	21.01
3.80	High Volume Growth2	April 2013	000	3.55	7.37
4.00	High Volume Growth2	April 2013	000	3.75	9.78
1.03	High Volume Growth2	April 2013	ZZZ	1.03	0.77
1.32	High Volume Growth2	April 2013	ZZZ	1.32	0.93
2.88	Harvard Valued - Utilization over 3(	October 2015	000	2.88	4.90
2.78	Harvard Valued - Utilization over 3(	October 2015	000	2.78	NA
5.00	High Volume Growth2	October 2014	000	4.46	32.45
5.50	High Volume Growth2	October 2014	000	4.96	33.33
1.70	High Volume Growth2	October 2014	ZZZ	1.4	2.12
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Deleted from CPT	Codes Reported Together 75%or M	October 2017	000		
4.00	Codes Reported Together 75%or M	April 2019	000	3.18	24.27
Deleted from CPT	Harvard Valued - Utilization over 3(	September 2011			
Deleted from CPT	Harvard Valued - Utilization over 3(	September 2011			
Deleted from CPT	Harvard Valued - Utilization over 3(	April 2011			
No reliable way to detern	CMS Request to Re-Review Familie	November 2011	090	27.28	NA
No reliable way to detern	CMS Request to Re-Review Familie	November 2011	090	25.82	NA
No reliable way to detern	CMS Request to Re-Review Familie	November 2011	090	27.44	NA
Request further informat	CMS Request to Re-Review Familie	November 2011	090	25.24	NA
3.50	Harvard Valued - Utilization over 3(	April 2011	000	3.04	NA
1.82	Harvard Valued - Utilization over 3(	October 2012	000	1.82	5.07
2.27	Harvard Valued - Utilization over 3(	October 2012	000	2.27	7.14
2.50	Harvard Valued - Utilization over 3(	October 2012	000	2.5	19.31
3.62	Harvard Valued - Utilization over 3(	October 2012	000	3.12	16.44
No reliable way to detern	CMS Fastest Growing	October 2008	090	24.64	NA
Deleted from CPT	Negative IWPUT	September 2018			
Deleted from CPT	Negative IWPUT	September 2018			
Deleted from CPT	Negative IWPUT	April 2017			
5.00	Negative IWPUT	September 2018	000	4.4	NA
5.50	Negative IWPUT	September 2018	000	4.62	NA

6.00	Negative IWPUT	September 2018	000	5.4	NA
5.00	Negative IWPUT	September 2018	000	4.29	NA
14.31	Negative IWPUT	April 2018	090	14.31	NA
13.20	Negative IWPUT	April 2017	090	13.2	NA
8.05	Codes Reported Together 75% or M	February 2010	090	7.8	NA
8.77	Codes Reported Together 75% or M	February 2010	090	8.52	NA
5.26	Codes Reported Together 75% or M	February 2010	090	5.01	NA
5.53	CMS Fastest Growing / Codes Repo	October 2008	090	5.28	NA
5.80	Codes Reported Together 75% or M	April 2011	090	5.55	NA
5.50	Codes Reported Together 75% or M	April 2011	090	5.25	NA
5.77	Codes Reported Together 75% or M	April 2011	090	5.52	NA
6.04	Codes Reported Together 75% or M	April 2011	090	5.79	NA
6.32	Codes Reported Together 75% or M	April 2011	090	6.07	NA
6.59	Codes Reported Together 75% or M	April 2011	090	6.34	NA
3.39	Codes Reported Together 75% or M	February 2010	090	3.14	NA
6.06	Codes Reported Together 75% or M	February 2010	090	5.8	NA
3.29	Codes Reported Together 75% or M	February 2010	090	3.04	NA
15.17	Codes Reported Together 75% or M	February 2010	090	14.92	NA
6.06	Codes Reported Together 75% or M	April 2011	090	5.81	NA
6.33	Codes Reported Together 75% or M	April 2011	090	6.08	NA
6.60	Codes Reported Together 75% or M	April 2011	090	6.35	NA
3.50	CMS Request - Final Rule for 2013	October 2012			
3.00	CMS Request - Final Rule for 2013	October 2012			
41.32	CMS High Expenditure Procedural C	September 2011	090	41.32	NA
50.93	High IWPUT / CMS High Expenditur	February 2008	090	50.93	NA
34.98	CMS High Expenditure Procedural C	September 2011	090	33.75	NA
CPT Article published July	New Technology/New Services / CP	January 2015	090	30	NA
CPT Article published July	New Technology/New Services / Cl	January 2015	090	16.18	NA
CPT Article published July	New Technology/New Services / CP	January 2015	090	64	NA
14.00	CMS Request - Final Rule for 2019	September 2019	000	14	NA
20.00	CMS Request - Final Rule for 2019	September 2019	000	20	NA
10.50	CMS Request - Final Rule for 2019	September 2019	ZZZ	8	NA
Remove from screen	High IWPUT	February 2008	090	58.79	NA
16.00	CMS Request - Final Rule for 2014	November 2014	090	89.5	NA
6.00	CMS Request - Final Rule for 2014	November 2014	XXX	6	NA
6.63	CMS Request - Final Rule for 2014	November 2013	XXX	6.63	NA
4.73	CMS Request - Final Rule for 2014	November 2013	XXX	4.73	NA
4.60	CMS Request - Final Rule for 2014	November 2013	XXX	4.6	NA
8.15	CMS Request - Final Rule for 2014	November 2013	000	8.15	NA
8.43	CMS Request - Final Rule for 2014	November 2013	000	8.15	NA
9.83	CMS Request - Final Rule for 2014	November 2013	000	9.11	NA
9.43	CMS Request - Final Rule for 2014	November 2014	000	9.11	NA
16.00	CMS Request - Final Rule for 2014	November 2014	000	16	NA
4.00	CMS Request - Final Rule for 2014	November 2014	000	3.51	NA
4.05	CMS Request - Final Rule for 2014	November 2014	000	3.51	NA
4.69	CMS Request - Final Rule for 2014	November 2014	000	4.47	NA
Deleted from CPT	CMS Request - Final Rule for 2014	July 2013			

Deleted from CPT	CMS Request - Final Rule for 2014	July 2013			
4.73	CMS Request - Final Rule for 2014	November 2014	000	4.47	NA
9.00	CMS Request - Final Rule for 2014	November 2014	000	9	NA
9.50	CMS Request - Final Rule for 2014	November 2014	000	9.5	NA
3.51	CMS Request - Final Rule for 2014	November 2014	000	3.51	NA
4.50	CMS Request - Final Rule for 2014	November 2014	000	4.5	NA
6.00	CMS Request - Final Rule for 2014	November 2014	000	5.22	NA
6.38	CMS Request - Final Rule for 2014	November 2014	000	5.46	NA
9.89	CMS Request - Final Rule for 2014	November 2014	000	9.89	NA
10.00	CMS Request - Final Rule for 2014	November 2014	000	10	NA
4.08	CMS Request - Final Rule for 2014	November 2014	ZZZ	4.04	NA
15.00	CMS Request - Final Rule for 2014	November 2014	000	15	NA
9.50	CMS Request - Final Rule for 2014	November 2013	000	9.5	NA
23.71	Codes Reported Together 75%or M	January 2017	090	23.71	NA
36.00	Codes Reported Together 75%or M	January 2017	090	36	NA
26.52	Codes Reported Together 75%or M	January 2017	090	26.52	NA
45.00	Codes Reported Together 75%or M	January 2017	090	45	NA
29.58	Codes Reported Together 75%or M	January 2017	090	29.58	NA
45.00	Codes Reported Together 75%or M	January 2017	090	45	NA
22.28	Codes Reported Together 75%or M	January 2017	090	22.28	NA
36.50	Codes Reported Together 75%or M	January 2017	090	36.5	NA
6.50	Codes Reported Together 75%or M	January 2017	ZZZ	6.5	NA
15.00	Codes Reported Together 75%or M	January 2017	090	15	NA
6.00	Codes Reported Together 75%or M	January 2017	ZZZ	6	NA
12.00	Codes Reported Together 75%or M	January 2017	090	12	NA
2.50	Codes Reported Together 75%or M	January 2017	ZZZ	2.5	NA
5.25	Codes Reported Together 75%or M	January 2017	ZZZ	5.25	NA
6.00	Codes Reported Together 75%or M	January 2017	ZZZ	6	NA
7.19	Codes Reported Together 75%or M	January 2017	ZZZ	7.19	NA
Deleted from CPT	Codes Reported Together 75%or M	October 2015			
Deleted from CPT	Pre-Time Analysis / Codes Reportec	January 2014			
Deleted from CPT	Codes Reported Together 75%or M	October 2015			
Deleted from CPT	Codes Reported Together 75%or M	October 2015			
Deleted from CPT	Codes Reported Together 75%or M	January 2017			
Deleted from CPT	Codes Reported Together 75%or M	January 2017			
4.13	Pre-Time Analysis	January 2014	ZZZ	4.13	NA
7.00	Codes Reported Together 75%or M	January 2017	ZZZ	7	NA
Deleted from CPT	Pre-Time Analysis / Codes Reportec	January 2014			
Deleted from CPT	Codes Reported Together 75%or M	January 2017			
8.16	Codes Reported Together 75%or M	January 2017	ZZZ	8.16	NA
2.65	Codes Reported Together 75%or M	January 2017	ZZZ	2.65	NA
Deleted from CPT	Codes Reported Together 75%or M	January 2017			
21.16	CMS High Expenditure Procedural C	September 2011	090	21.16	NA
Deleted from CPT	Codes Reported Together 75% or M	October 2015			
Deleted from CPT	Codes Reported Together 75% or M	October 2015			
Deleted from CPT	CMS Fastest Growing	February 2010			
Deleted from CPT	CMS Fastest Growing	February 2010			

Deleted from CPT	Codes Reported Together 75% or M	October 2015			
Deleted from CPT	CMS Fastest Growing	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	October 2015			
Deleted from CPT	CMS Fastest Growing	October 2008			
Deleted from CPT	CMS Fastest Growing / Codes Repo	October 2009			
Deleted from CPT	CMS Fastest Growing / Codes Repo	October 2009			
Deleted from CPT	CMS Fastest Growing	February 2010			
Deleted from CPT	CMS Fastest Growing	October 2008			
Deleted from CPT	CMS Fastest Growing / CMS High E	September 2011			
Deleted from CPT	CMS Fastest Growing / CMS High E	September 2011			
Deleted from CPT	High Volume Growth1	April 2008			
Deleted from CPT	High Volume Growth1	April 2008			
Deleted from CPT	High Volume Growth1	April 2008			
Deleted from CPT	High Volume Growth1	February 2008			
Deleted from CPT	High Volume Growth1	April 2008			
Deleted from CPT	High Volume Growth1	February 2008			
7.50	Negative IWPUT	January 2018	090	7.5	NA
7.12	Negative IWPUT	September 2018	090	7.12	NA
7.50	Negative IWPUT	September 2018	090	7.5	NA
Deleted from CPT	Negative IWPUT	January 2018			
Deleted from CPT	Negative IWPUT	January 2018			
Deleted from CPT	Negative IWPUT	April 2017			
CMS consider a bundled s	Harvard Valued - Utilization over 10	October 2009	XXX	0.18	0.67
Remove from re-review.	Codes Reported Together 75% or M	February 2010	XXX	2.18	14.12
Remove from re-review	Harvard Valued - Utilization over 30	April 2011	XXX	1.76	13.35
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
4.17	Codes Reported Together 75% or M	February 2010	000	4.17	28.04
5.27	Codes Reported Together 75% or M	February 2010	000	5.27	27.97
6.29	Harvard Valued - Utilization over 30	April 2011	000	6.29	49.17
1.01	CMS High Expenditure Procedural C	July 2015	ZZZ	1.01	5.35
4.51	Codes Reported Together 75% or M	February 2010	000	3.92	27.05
6.00	Codes Reported Together 75% or M	February 2010	000	5.28	31.56
6.50	Codes Reported Together 75% or M	February 2010	000	5.75	42.78
7.55	Codes Reported Together 75% or M	February 2010	000	6.25	55.63
6.50	Codes Reported Together 75% or M	February 2010	000	5.75	40.17
7.55	Codes Reported Together 75% or M	February 2010	000	6.25	52.87
2.32	Codes Reported Together 75% or M	February 2010	ZZZ	2.09	4.66
4.25	Codes Reported Together 75% or M	February 2010	ZZZ	4.25	34.39
4.90	Harvard Valued - Utilization over 10	October 2009	XXX	4.65	34.72
5.27	Harvard Valued - Utilization over 10	February 2010	000	5.02	20.12
7.00	Harvard Valued - Utilization over 10	February 2010	000	6.04	38.48
Remove from screen	CMS Fastest Growing	October 2008	ZZZ	1.01	2.71
5.45	Codes Reported Together 75% or M	February 2011	000	5.1	35.66
7.38	Codes Reported Together 75% or M	February 2011	000	6.74	36.70
7.55	Codes Reported Together 75% or M	February 2011	000	7.3	57.15

8.15	Codes Reported Together 75% or M	February 2011	000	7.9	54.59
0.18	Harvard Valued - Utilization over 10	October 2009	XXX	0.18	0.31
5.30	High Volume Growth2	April 2013	000	5.3	31.36
2.65	High Volume Growth2	October 2013	ZZZ	2.65	5.77
5.30	High Volume Growth2	April 2013	000	5.3	25.42
2.65	High Volume Growth2	April 2013	ZZZ	2.65	6.26
New PE Inputs	CMS Request - Practice Expense Re	NA	000	6.73	49.03
2.00. Refer to CPT Assista	CMS Request - Final Rule for 2016	January 2017	000	2	NA
2.00. Refer to CPT Assista	CMS Request - Final Rule for 2016	January 2017	000	2	NA
2.00. Refer to CPT Assista	CMS Request - Final Rule for 2016	January 2017	000	2	NA
1.81. Refer to CPT Assista	CMS Request - Final Rule for 2016	January 2017	000	1.81	17.01
Deleted from CPT	CMS Request - Final Rule for 2016	January 2017			
1.56. Refer to CPT Assista	CMS Fastest Growing / CMS Reque	October 2008	000	1.56	56.69
1.75. Refer to CPT Assista	CMS Request - Final Rule for 2016	January 2017	000	1.75	48.78
1.93	CMS High Expenditure Procedural C	July 2015	000	1.93	3.70
1.75	CMS High Expenditure Procedural C	July 2015	000	1.75	4.60
2.11	Identified in RUC review of other se	October 2016	000	2.11	NA
1.90. Review at RAW in O	CMS High Expenditure Procedural C	July 2015	000	1.9	NA
2.00	CMS High Expenditure Procedural C	September 2017	000	1.82	11.35
1.90	CMS High Expenditure Procedural C	September 2017	000	1.7	10.27
1.47	Identified in RUC review of other se	October 2016	000	1.2	9.21
1.00	CMS High Expenditure Procedural C	July 2015	000	1	NA
13.00	CMS Request - Final Rule for 2013	November 2012	090	12.39	NA
15.00	CMS Request - Final Rule for 2013	November 2012	090	13.29	NA
13.99	Site of Service Anomaly / CMS Requ	September 2007	090	13.07	NA
11.90	Site of Service Anomaly / CMS Requ	September 2007	090	11.9	NA
Deleted from CPT	CMS Request - Final Rule for 2014	February 2011			
15.93	Site of Service Anomaly / CMS Requ	September 2007	090	14.17	NA
11.90	CMS Request - Final Rule for 2013	November 2012	090	12.03	NA
Deleted from CPT	Site of Service Anomaly	September 2007			
Deleted from CPT	Site of Service Anomaly (99238-Onl	September 2007			
3.36	Codes Reported Together 75% or M	October 2015	000	3.36	17.84
4.83	Codes Reported Together 75% or M	October 2015	000	4.83	33.47
6.39	Codes Reported Together 75% or M	October 2015	000	6.39	140.30
7.50	Codes Reported Together 75% or M	October 2015	000	7.5	48.72
9.00	Codes Reported Together 75% or M	October 2015	000	9	63.02
10.42	Codes Reported Together 75% or M	October 2015	000	10.42	173.18
3.00	Codes Reported Together 75% or M	October 2015	ZZZ	3	16.34
4.25	Codes Reported Together 75% or M	October 2015	ZZZ	4.25	49.50
4.12	Codes Reported Together 75% or M	October 2015	ZZZ	4.12	57.02
New PE inputs	CMS Request - Practice Expense Re	NA	000	7.74	180.49
4.71	Codes Reported Together 75% or M	February 2011	000	4.46	63.97
8.00	Codes Reported Together 75% or M	February 2011	000	7.1	31.60
8.00	Codes Reported Together 75% or M	February 2011	000	7.1	39.56
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			

Deleted from CPT	High Volume Growth1 / Codes Rep	February 2010			
Deleted from CPT	High Volume Growth1	February 2010			
Deleted from CPT	High Volume Growth1	February 2010			
Deleted from CPT	High Volume Growth1	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
8.00	Codes Reported Together 75% or M	February 2010	000	7.75	NA
7.06	Codes Reported Together 75% or M	February 2010	000	6.81	NA
5.00	Codes Reported Together 75% or M	February 2010	000	4.75	NA
3.04	Codes Reported Together 75% or M	February 2010	000	2.49	NA
Refer to CPT. 8.15	High Volume Growth1	February 2010	000	7.9	74.19
Refer to CPT. 10.00	High Volume Growth1	February 2010	000	9.75	96.83
Refer to CPT. 3.73	High Volume Growth1	February 2010	ZZZ	3.73	16.14
Refer to CPT. 4.25	High Volume Growth1	February 2010	ZZZ	4.25	44.04
Refer to CPT. 9.00	High Volume Growth1	February 2010	000	8.75	88.47
Refer to CPT.	High Volume Growth1 / PE Screen -	February 2010	000	11.75	299.74
Refer to CPT. 10.49	High Volume Growth1	February 2010	000	10.24	273.20
Refer to CPT. 14.50	High Volume Growth1 / PE Screen -	February 2010	000	14.25	385.21
Refer to CPT. 11.00	High Volume Growth1	February 2010	000	10.75	128.91
Refer to CPT. 14.05	High Volume Growth1 / PE Screen -	February 2010	000	13.8	299.25
Refer to CPT. 13.80	High Volume Growth1	February 2010	000	13.55	284.04
Refer to CPT. 15.00	High Volume Growth1	February 2010	000	14.75	386.13
Refer to CPT. 4.00	High Volume Growth1	February 2010	ZZZ	4	23.55
Refer to CPT. 6.50	High Volume Growth1	February 2010	ZZZ	6.5	27.13
Refer to CPT. 5.50	High Volume Growth1	February 2010	ZZZ	5.5	111.73
Refer to CPT. 7.80	High Volume Growth1	February 2010	ZZZ	7.8	116.61
9.00	Codes Reported Together 75% or M	February 2013	000	8.75	84.52
4.25	Codes Reported Together 75% or M	February 2013	ZZZ	4.25	43.32
6.29	Codes Reported Together 75% or M	February 2013	000	6.04	106.77
3.34	Codes Reported Together 75% or M	February 2013	ZZZ	2.97	53.45
9.00	Codes Reported Together 75% or M	February 2010	000	8.75	137.81
11.98	Codes Reported Together 75% or M	February 2010	000	9.8	220.06
14.00	Codes Reported Together 75% or M	February 2010	000	11.74	271.90
14.00	Codes Reported Together 75% or M	February 2010	000	13.75	198.34
7.00	Codes Reported Together 75% or M	October 2015	000	7	51.34
3.50	Codes Reported Together 75% or M	October 2015	ZZZ	3.5	14.34
6.00	Codes Reported Together 75% or M	October 2015	000	6	37.31
2.97	Codes Reported Together 75% or M	October 2015	ZZZ	2.97	11.33
Deleted from CPT	Final Rule for 2015	July 2014			
Deleted from CPT	Final Rule for 2015	July 2014			
1.80	Final Rule for 2015 / Work Neutrali	July 2014	ZZZ	1.8	30.84
1.44	Final Rule for 2015 / Work Neutrali	July 2014	ZZZ	1.44	3.65
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	010	3.05	5.75
37.60	Codes Reported Together 75% or M	February 2011	090	30	NA
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
10.69	Site of Service Anomaly	September 2007	090	10.78	NA
9.00	Site of Service Anomaly	April 2009	090	9.13	NA

4.80	High Volume Growth1 / CMS Faste:	February 2008	010	4.8	7.22
6.00	High Volume Growth1 / CMS Faste:	February 2008	010	6	7.92
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	3.93	5.80
1.20	CMS High Expenditure Procedural C	February 2016	XXX	1.2	3.57
1.28	CMS High Expenditure Procedural C	July 2015	XXX	1.28	3.37
1.44	CMS High Expenditure Procedural C	February 2016	XXX	1.44	3.65
1.59	Harvard Valued - Utilization over 3(	October 2019	000	1.14	2.36
7.85	Site of Service Anomaly	September 2007	090	7.95	NA
9.34	010-Day Global Post-Operative Visi	January 2014	010	8.49	NA
12.00	CMS Fastest Growing / 010-Day Glc	October 2008	010	12	NA
15.60	010-Day Global Post-Operative Visi	January 2014	010	15.6	NA
0.65	Negative IWPUT	April 2017	000	0.65	1.72
Deleted from CPT	Pre-Time Analysis	January 2014			
5.44	Pre-Time Analysis	October 2014	000	5.44	NA
7.50	Pre-Time Analysis	October 2014	000	7.25	NA
1.22	Harvard Valued - Utilization over 3(	April 2011	000	1.22	2.34
PE Clinical staff pre-time i	Emergent Procedures	October 2015	090	3.78	9.72
Maintain	010-Day Global Post-Operative Visi	January 2014	010	1.23	4.87
Maintain. Reduced 99238	Site of Service Anomaly (99238-Onl	September 2007	010	2.63	5.88
1.05	Negative IWPUT	April 2017	010	1.05	3.81
Maintain	010-Day Global Post-Operative Visi	January 2014	010	2.37	5.96
Maintain	010-Day Global Post-Operative Visi	January 2014	010	1.34	6.47
3.50	Final Rule for 2015	July 2014	000	3.5	25.25
9.63	Site of Service Anomaly	September 2007	090	9.78	NA
18.12	Site of Service Anomaly	September 2007	090	17.16	NA
21.00	Site of Service Anomaly	September 2007	090	19.53	NA
7.13	Site of Service Anomaly	September 2007	090	6.14	NA
2.78	MPC List	September 2011	000	2.49	NA
3.21	MPC List	September 2011	000	2.79	NA
3.36	MPC List	September 2011	000	2.79	NA
3.99	MPC List	September 2011	000	3.51	NA
3.21	MPC List	September 2011	000	3.07	NA
3.36	MPC List	September 2011	000	3.31	NA
1.59	MPC List	September 2011	000	1.52	4.07
1.89	MPC List	September 2011	000	1.82	4.32
1.59	MPC List	September 2011	000	1.42	6.21
1.90	MPC List	September 2011	000	1.72	5.78
1.89	MPC List	September 2011	000	1.72	8.94
2.89	MPC List	September 2011	000	2.33	NA
3.00	MPC List	September 2011	000	2.44	NA
2.39	MPC List	September 2011	000	2.29	6.52
4.58	MPC List	September 2011	000	4.2	NA
3.73	MPC List	September 2011	000	3.4	NA
5.00	MPC List	September 2011	000	4.63	33.35
3.78	MPC List	September 2011	000	3.4	NA
2.60	MPC List	September 2011	000	2.44	9.30
2.40	MPC List	September 2011	000	2.3	10.01

2.90	MPC List	September 2011	000	2.8	9.72
Deleted from CPT	MPC List	September 2011			
2.10	MPC List	September 2011	000	2	27.96
2.34	MPC List	September 2011	000	2.24	8.98
3.26	MPC List	September 2011	000	2.89	15.89
Deleted from CPT	MPC List	September 2011			
3.72	MPC List	September 2011	000	3.49	18.25
3.19	MPC List	September 2011	000	2.8	NA
3.83	MPC List	September 2011	000	3.59	NA
4.45	MPC List	October 2012	000	4.07	NA
Deleted from CPT	MPC List	September 2011			
2.26	MPC List / CMS High Expenditure P	October 2010	000	2.09	6.59
2.57	CMS Fastest Growing / MPC List	October 2008	000	2.39	9.43
3.85	MPC List	September 2011	000	3.47	NA
4.50	MPC List	September 2011	000	4.16	NA
2.39	MPC List / CMS Request - Final Rule	October 2010	000	2.39	8.84
7.25	MPC List	September 2011	000	7.15	NA
2.59	MPC List	September 2011	000	2.49	NA
5.39	CMS Fastest Growing / MPC List	October 2008	000	4.73	NA
4.37	MPC List	September 2011	000	4.27	NA
4.50	MPC List	September 2011	000	4.4	NA
3.18	MPC List	September 2011	000	3.08	15.04
4.32	MPC List	September 2011	000	3.56	NA
3.27	MPC List	September 2011	000	3.11	8.12
3.01	MPC List	September 2011	000	2.91	9.18
2.77	MPC List	September 2011	000	2.67	31.47
3.07	MPC List	September 2011	000	2.97	10.44
3.57	MPC List	September 2011	000	3.47	11.28
5.39	MPC List	February 2012	000	4.73	NA
5.25	MPC List	October 2012	000	4.87	NA
4.20	MPC List	September 2011	000	3.56	16.12
Deleted from CPT	MPC List	September 2011			
4.25	MPC List	September 2011	000	4.15	NA
Deleted from CPT	MPC List	September 2011			
4.74	CMS Fastest Growing	October 2008	000	4.04	NA
5.95	MPC List	September 2011	000	5.85	NA
6.25	MPC List	September 2011	000	6.15	NA
6.60	MPC List	September 2011	000	6.5	NA
7.28	MPC List	September 2011	000	6.5	NA
6.73	Harvard Valued - Utilization over 3(	April 2011	000	6.63	NA
8.03	MPC List	September 2011	000	7.93	NA
4.40	MPC List	October 2012	000	3.92	NA
Deleted from CPT	MPC List	September 2011			
Deleted from CPT	Harvard Valued - Utilization over 3(	April 2011			
Deleted from CPT	MPC List	September 2011			
4.39	MPC List	October 2012	000	4.01	18.21
Deleted from CPT	MPC List	September 2011			

Deleted from CPT	MPC List	September 2011			
2.24	MPC List	September 2011	ZZZ	2.24	NA
8.74	MPC List	September 2011	000	8.48	NA
6.96	MPC List	September 2011	000	6.86	NA
9.10	MPC List	September 2011	000	8.84	NA
7.11	MPC List	September 2011	000	6.9	NA
8.08	MPC List	September 2011	000	7.92	NA
1.30	MPC List	September 2011	000	1.28	4.18
1.51	MPC List	September 2011	000	1.41	25.10
Deleted from CPT	MPC List	September 2011			
Deleted from CPT	MPC List	September 2011			
Deleted from CPT	CMS 000-Day Global Typically Repo	July 2016			
0.75. Flag for Re-review.	CMS 000-Day Global Typically Repo	September 2017	000	0.75	6.23
1.41. Flag for Re-review.	CMS 000-Day Global Typically Repo	September 2017	000	1.41	9.02
99214 visit appropriate. F	High Level E/M in Global Period	October 2015	090	27.79	NA
Remove from screen	CMS Fastest Growing	October 2008	090	22.95	NA
Remove from screen	CMS Fastest Growing	February 2008	090	31.92	NA
0.97	MPC List	September 2011	000	0.87	4.95
1.48	MPC List	May 2013	000	1.38	29.46
1.27	MPC List	September 2011	000	1.17	7.87
Deleted from CPT	MPC List	September 2011			
3.11	MPC List	May 2013	000	2.85	NA
1.30	MPC List	September 2011	000	1.2	5.09
1.60	MPC List	September 2011	000	1.5	7.87
2.82	MPC List	September 2011	000	2.72	6.39
3.12	MPC List	September 2011	000	3.02	9.13
3.82	MPC List	September 2011	000	3.74	8.05
4.22	MPC List	September 2011	000	4.12	15.88
3.63	MPC List	September 2011	000	3.53	7.58
Deleted from CPT	MPC List	September 2011			
4.13	MPC List	September 2011	000	4.03	8.72
Deleted from CPT	MPC List	September 2011			
4.44	MPC List	September 2011	000	4.34	77.43
4.96	MPC List	January 2014	000	4.7	NA
5.81	MPC List	January 2014	000	5.5	NA
3.13	MPC List	January 2014	000	3.02	9.22
3.33	MPC List	January 2014	000	3.23	13.75
4.41	MPC List	January 2014	000	4.1	NA
5.06	MPC List	January 2014	000	4.96	NA
4.24	MPC List	January 2014	000	4.14	NA
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Remove from screen	CMS Fastest Growing	October 2008	090	9.45	NA
Deleted from CPT	Site of Service Anomaly	September 2007			
8.00	Site of Service Anomaly	September 2007	090	8.13	NA
12.00	Site of Service Anomaly	September 2007	090	12.13	NA
0.80	CMS 000-Day Global Typically Repo	July 2016	000	0.8	2.99
0.84	Harvard Valued - Utilization over 30	April 2011	000	0.84	4.65

1.14	MPC List	September 2011	000	1.14	7.50
1.85	MPC List	September 2011	000	1.76	6.40
1.65	MPC List	September 2011	000	1.55	8.32
2.10	MPC List	September 2011	000	2	13.83
1.15	MPC List	September 2011	000	1.04	7.61
2.20	MPC List	September 2011	000	2.1	NA
2.15	MPC List	September 2011	000	2.05	6.77
Deleted from CPT	MPC List	September 2011			
1.35	MPC List	September 2011	000	1.25	12.98
2.43	MPC List	September 2011	000	2.12	NA
3.08	MPC List	September 2011	000	2.98	NA
Deleted from CPT	MPC List	September 2011			
2.97	MPC List	May 2013	000	2.81	76.84
2.98	MPC List	May 2013	000	2.72	NA
3.83	MPC List	January 2014	000	3.52	NA
1.78	MPC List	January 2014	000	1.68	18.66
Deleted from CPT	MPC List	September 2011			
3.36	CMS High Expenditure Procedural C	September 2011	000	3.26	6.56
4.37	MPC List	September 2011	000	4.28	8.32
3.66	MPC List	October 2010	000	3.56	9.25
3.67	CMS Fastest Growing / MPC List / C	October 2008	000	3.56	9.36
4.76	MPC List	September 2011	000	4.66	16.07
Deleted from CPT	MPC List	September 2011			
4.17	MPC List	September 2011	000	4.07	10.23
4.57	MPC List / Codes Reported Togethe	October 2010	000	4.57	8.62
3.87	MPC List	September 2011	000	3.77	14.77
Deleted from CPT	MPC List	September 2011			
4.98	MPC List	January 2014	000	4.88	79.44
5.50	MPC List	January 2014	000	5.24	NA
6.35	MPC List	January 2014	000	6.04	NA
4.95	MPC List	September 2011	000	4.64	NA
5.60	MPC List	September 2011	000	5.5	NA
4.78	MPC List	January 2014	000	4.68	NA
4.30	MPC List	January 2014	000	4.2	20.44
3.50	010-Day Global Post-Operative Visi	October 2019	010	3	4.92
2.00	010-Day Global Post-Operative Visi	April 2020	010	1.26	3.09
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	3.59	10.05
2.00	010-Day Global Post-Operative Visi	January 2014	010	1.74	7.52
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
91.78	090-Day Global Post-Operative Visi	January 2014	090	90	NA
Deleted from CPT	090-Day Global Post-Operative Visi	April 2014			
New PE Inputs	CMS Request - Practice Expense Re	NA	010	14.97	108.30
4.76	CMS Fastest Growing	October 2008	010	4.76	NA
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			

Deleted from CPT	High IWPUT	February 2008			
Deleted from CPT	Codes Reported Together 75% or M	February 2015			
1.30	Codes Reported Together 75% or M	February 2015	000	1.3	11.26
4.50	Codes Reported Together 75% or M	February 2015	000	4.25	21.37
5.63	Codes Reported Together 75% or M	February 2015	000	5.38	31.52
7.85	Codes Reported Together 75% or M	February 2015	000	7.6	33.18
4.20	Codes Reported Together 75% or M	February 2015	000	3.95	24.60
2.86	Codes Reported Together 75% or M	February 2015	000	2.61	17.79
1.85	Codes Reported Together 75% or M	February 2015	000	1.84	12.71
5.00	Codes Reported Together 75% or M	February 2015	000	4.75	120.85
9.00	Codes Reported Together 75% or M	February 2015	000	8.75	128.69
9.28	Codes Reported Together 75% or M	February 2015	000	9.03	131.53
7.00	Codes Reported Together 75% or M	February 2015	000	6.75	29.20
2.85	Codes Reported Together 75% or M	February 2015	ZZZ	2.85	12.52
3.00	Codes Reported Together 75% or M	February 2015	ZZZ	3	9.70
3.28	Codes Reported Together 75% or M	February 2015	ZZZ	3.28	24.66
Deleted from CPT	CMS Request - Final Rule for 2014	July 2013			
Maintain work RVU and a	CMS High Expenditure Procedural C	September 2011	090	10.47	NA
No further action. 12.11	CMS High Expenditure Procedural C	September 2011	090	11.47	NA
20.00	CMS Request - Final Rule for 2012	September 2011	090	17.48	NA
21.00	CMS Request - Final Rule for 2012	September 2011	090	18.48	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	010	4.7	10.86
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Deleted from CPT	Harvard Valued - Utilization over 1C	October 2009			
Deleted from CPT	Harvard Valued - Utilization over 1C	February 2010			
1.35	Harvard Valued - Utilization over 1C	February 2010	000	1.24	5.06
2.00	Harvard Valued - Utilization over 1C	February 2010	000	2	6.90
2.50	Harvard Valued - Utilization over 1C	February 2010	000	2	NA
4.25	Codes Reported Together 75% or M	January 2012	000	4	22.98
4.25	Codes Reported Together 75% or M	January 2012	000	4	22.99
4.50	Codes Reported Together 75% or M	January 2012	000	4.25	18.03
4.21	Site of Service Anomaly	February 2010	000	3.96	29.31
Deleted from CPT	Site of Service Anomaly	April 2008			
4.21	Site of Service Anomaly	September 2007	000	4.21	NA
4.00	Site of Service Anomaly - 2016	October 2016	000	4	NA
Reaffirmed	CMS High Expenditure Procedural C	September 2011	090	7.96	NA
10.05	Site of Service Anomaly	September 2007	090	9.09	NA
12.44	Site of Service Anomaly	September 2007	090	11.48	NA
Refer to CPT	Site of Service Anomaly - 2019	October 2019	090	12.37	NA
8.04	Site of Service Anomaly	September 2007	090	7.08	NA
12.88	Site of Service Anomaly	June 2010	090	11.92	NA
16.21	Site of Service Anomaly	June 2010	090	14.94	NA
15.03	Site of Service Anomaly	June 2010	090	13.76	NA
18.11	Site of Service Anomaly	June 2010	090	16.84	NA

Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Refer to CPT	Site of Service Anomaly - 2019	October 2019	090	15.74	NA
Refer to CPT	Site of Service Anomaly - 2019	October 2019	090	23.5	NA
New PE Inputs	CMS Request - Practice Expense Re	NA	000	2.38	13.71
40.90	Harvard-Valued Annual Allowed Ch	July 2012	090	39.88	NA
2.00	Codes Reported Together 75% or M	October 2012	000	1.75	15.40
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2014			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
3.15	Codes Reported Together 75% or M	October 2014	000	2.9	15.41
1.42	Codes Reported Together 75% or M	October 2014	000	1.1	7.92
4.00	Codes Reported Together 75% or M	October 2014	000	4	23.39
5.05	Codes Reported Together 75% or M	September 2017	000	5.05	29.70
4.20	Codes Reported Together 75% or M	October 2014	000	3.75	24.12
2.00	Codes Reported Together 75% or M	October 2014	000	1.82	16.19
3.37	Codes Reported Together 75% or M	September 2017	000	2.78	NA
5.44	Codes Reported Together 75% or M	September 2017	000	4.85	NA
Remove from screen	CMS Fastest Growing	October 2008	090	21.36	NA
Remove from screen	CMS Fastest Growing	October 2008	090	25.36	NA
9.77	CMS High Expenditure Procedural C	September 2011	090	9.77	11.03
Review action plan at the	CMS Fastest Growing / CPT Assistar	October 2008	090	16.79	NA
3.16	Codes Reported Together 75% or M	October 2014	ZZZ	3.16	13.99
4.60	Codes Reported Together 75% or M	October 2014	000	3.96	27.17
6.00	Codes Reported Together 75% or M	October 2014	000	5.25	29.30
7.55	Codes Reported Together 75% or M	October 2014	000	6.8	34.84
4.03	Codes Reported Together 75% or M	October 2014	ZZZ	4.03	53.59
3.80	Codes Reported Together 75% or M	October 2014	ZZZ	3.8	23.29
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	4.49	NA
2.70	Site of Service Anomaly	September 2007	000	2.7	4.21
0.60	CMS High Expenditure Procedural C	July 2015	000	0.6	1.63
0.50	CMS High Expenditure Procedural C	July 2015	000	0.5	0.78
0.50	CMS High Expenditure Procedural C	July 2015	000	0.5	1.32
1.47	CMS High Expenditure Procedural C	July 2015	000	1.47	2.73
0.87	CMS High Expenditure Procedural C	July 2015	000	0.87	1.64
1.71	Codes Reported Together 95% or M	February 2008	000	1.71	7.14
2.11	Codes Reported Together 95% or M	February 2009	000	2.11	8.52
2.11	Codes Reported Together 95% or M	February 2009	000	2.11	8.65
2.51	Codes Reported Together 95% or M	February 2009	000	2.51	8.84
0.17	Harvard Valued - Utilization over 1(	February 2010	XXX	0.17	0.20
0.17	Harvard Valued - Utilization over 1(	October 2009	XXX	0.17	0.21
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
0.75. Maintain, CPT Assist	Codes Reported Together 75% or M	October 2012	XXX	0.75	1.11
CPT edits and CPT Assista	Codes Reported Together 75% or M	October 2012	000	1.1	6.72
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
0.80	Codes Reported Together 95% or M	February 2008	ZZZ	0.8	4.66

PE Only	CMS High Expenditure Procedural C	July 2015	XXX	0	0.29
1.75	MPC List / CMS High Expenditure Pı	October 2010	000	1.53	5.21
3.50	High Volume Growth1 / CPT Assista	June 2008	000	3.5	19.06
4.05	High Volume Growth1 / CPT Assista	February 2008	000	4.05	19.41
4.62	Harvard Valued - Utilization over 3(	September 2011	000	4.62	NA
5.44	Harvard Valued - Utilization over 3(	April 2011	000	5.44	NA
8.75	Harvard Valued - Utilization over 3(	September 2011	000	7.5	NA
2.80	Harvard Valued - Utilization over 1(	October 2009	000	2.75	6.79
Remove from Screen	High Volume Growth6	October 2019	000	3.2	7.82
2.82	Harvard Valued - Utilization over 1(	October 2009	000	2.82	9.94
3.37	Codes Reported Together 75% or M	September 2017	000	3.37	NA
5.35	Site of Service Anomaly	April 2008	000	5.35	NA
5.85	Site of Service Anomaly	April 2008	000	5.85	NA
6.55	Site of Service Anomaly	April 2008	000	6.55	NA
7.05	Site of Service Anomaly	September 2007	000	7.05	NA
7.55	Site of Service Anomaly	April 2008	000	7.55	NA
8.58	Site of Service Anomaly	April 2008	000	8.58	NA
5.75	Harvard Valued - Utilization over 3(	September 2011	000	5.75	NA
6.75	Harvard Valued - Utilization over 3(	September 2011	000	6.75	NA
7.50	Harvard Valued - Utilization over 3(	April 2011	000	7.5	NA
8.58	Harvard Valued - Utilization over 3(	September 2011	000	8	NA
10.00	Harvard Valued - Utilization over 3(	September 2011	000	9	NA
8.00	Codes Reported Together 75% or M	January 2013	000	8	NA
8.69	Site of Service Anomaly	September 2007	090	8.69	NA
Maintain	PE Units Screen	April 2020	ZZZ	1.01	28.12
8.14	Site of Service Anomaly	September 2007	090	8.14	NA
13.16	Site of Service Anomaly - 2015	October 2015	090	13.16	NA
4.79	Site of Service Anomaly	September 2007	090	4.79	NA
Remove from screen	High Volume Growth1	February 2008	090	12.15	36.73
13.00	Site of Service Anomaly	September 2007	090	13	NA
10.08	CMS High Expenditure Procedural C	September 2011	090	5.42	40.18
14.39	Site of Service Anomaly	September 2007	090	14.52	NA
15.18	Site of Service Anomaly	September 2007	090	15.18	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	5.3	NA
8.46	Site of Service Anomaly	September 2007	090	8.46	NA
2.50	CMS High Expenditure Procedural C	July 2015	000	2.5	4.57
Maintain	010-Day Global Post-Operative Visi	January 2014	010	6.28	NA
21.36	CMS Request - Final Rule for 2014	October 2013	090	21.36	NA
24.16	CMS Request - Final Rule for 2014	October 2013	090	21.36	NA
29.07	CMS Request - Final Rule for 2014	July 2013	090	25.18	NA
26.80	New Technology / CMS Fastest Gro	September 2007	090	26.8	NA
13.45	CMS Request - Practice Expense Re	September 2007	090	13.6	171.52
Review data at RAW	RUC request	April 2015	090	13.46	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	010	3.08	4.41
7.35	Site of Service Anomaly	September 2007	090	7.53	NA
0.50	CMS 000-Day Global Typically Repo	July 2016	000	0.5	1.13
5.40	Site of Service Anomaly / Different	September 2007	000	5.15	5.80

2.69	Site of Service Anomaly	September 2007	000	2.69	3.65
0.89	CMS 000-Day Global Typically Repo	July 2016	000	0.89	1.11
10.08	Site of Service Anomaly - 2015	October 2015	090	10.08	NA
10.08	Site of Service Anomaly - 2015	April 2016	090	10.08	NA
13.25	Site of Service Anomaly - 2015	April 2016	090	13.25	NA
15.00	Site of Service Anomaly - 2015	April 2016	090	15	NA
13.48	Site of Service Anomaly - 2019	October 2019	090	11.63	NA
13.51	Site of Service Anomaly - 2019	October 2019	090	11.66	NA
10.97	Site of Service Anomaly	September 2007	090	11.15	NA
12.00	New Technology	September 2007	090	12.13	NA
18.02	Site of Service Anomaly - 2019	October 2019	090	17.03	NA
1.21	CMS 000-Day Global Typically Repo	July 2016	000	1.21	1.60
0.77	CMS 000-Day Global Typically Repo	April 2017	ZZZ	0.77	0.59
3.07	CMS Request - Practice Expense Re	NA	000	2.65	7.57
4.37	CMS Request - Practice Expense Re	NA	000	4.17	38.05
5.54	CMS High Expenditure Procedural C	July 2015	000	5.2	NA
6.15	CMS High Expenditure Procedural C	July 2015	000	5.75	NA
7.00	CMS High Expenditure Procedural C	July 2015	000	6.6	NA
4.17	CMS Request - Practice Expense Re	NA	000	4	8.07
4.62	CMS Request - Practice Expense Re	NA	000	4.47	59.54
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	11.59	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	010	11.35	NA
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
32.69	High IWPUT	February 2008	MMM	36.58	NA
14.37	High IWPUT	February 2008	MMM	14.37	NA
18.54	High IWPUT	February 2008	MMM	18.34	NA
1.71	High IWPUT	April 2008	MMM	1.71	NA
1.61	High IWPUT	April 2008	MMM	1.61	NA
6.31	High IWPUT	April 2008	MMM	7.8	6.63
11.16	High IWPUT	April 2008	MMM	14.3	12.14
2.47	High IWPUT	April 2008	MMM	3.22	3.59
36.17	High IWPUT	February 2008	MMM	40.39	NA
16.13	High IWPUT	October 2008	MMM	16.13	NA
22.00	High IWPUT	April 2008	MMM	22.13	NA
34.40	High IWPUT	April 2008	MMM	38.29	NA
16.09	High IWPUT	April 2008	MMM	16.09	NA
20.26	High IWPUT	April 2008	MMM	20.06	NA
36.69	High IWPUT	April 2008	MMM	40.91	NA
16.66	High IWPUT	April 2008	MMM	16.66	NA
22.53	High IWPUT	April 2008	MMM	22.66	NA
12.29	Site of Service Anomaly	September 2007	090	11.19	NA
14.67	Site of Service Anomaly	September 2007	090	14.79	NA
No reliable way to detern	CMS Request to Re-Review Familie	November 2011	090	17.16	NA
No reliable way to detern	CMS Request to Re-Review Familie	November 2011	090	19.18	NA
No reliable way to detern	CMS Request to Re-Review Familie	November 2011	090	23.48	NA
Editorial change	Codes Reported Together 75% or M	January 2014	000	2.1	NA
3.75	CMS Fastest Growing	October 2009	ZZZ	3.75	NA

3.18	CMS Fastest Growing	October 2009	ZZZ	3.18	NA
3.75	CMS Fastest Growing	October 2009	ZZZ	3.75	NA
Deleted from CPT	CMS Fastest Growing, Site of Servic	September 2007			
Deleted from CPT	CMS Fastest Growing	October 2008			
15.50	CMS Request - 2009 Final Rule	NA	090	13.93	NA
3.48	CMS Request - 2009 Final Rule	NA	ZZZ	3.48	NA
19.75	CMS Request - 2009 Final Rule	NA	090	19.85	NA
4.81	CMS Request - 2009 Final Rule	NA	ZZZ	4.81	NA
2.25	CMS Fastest Growing, Site of Servic	February 2008	ZZZ	2.25	NA
6.44	Site of Service Anomaly	September 2007	090	6.05	NA
6.54	Site of Service Anomaly	September 2007	010	5	13.40
1.44	Different Performing Specialty from	October 2017	000	1.22	2.50
1.80	Different Performing Specialty from	September 2018	000	1.58	3.31
Remove 99238	Site of Service Anomaly (99238-Onl	September 2007	010	2.66	4.32
1.54	Codes Reported Together 75% or M	October 2012	000	1.54	4.18
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	9.03	NA
3.00, CPT Assistant article	Different Performing Specialty from	October 2009	000	3	7.65
2.29	Codes Reported Together 75% or M	October 2012	000	2.29	5.30
2.29	Codes Reported Together 75% or M	October 2012	000	2.29	5.43
2.25	Codes Reported Together 75% or M	October 2012	000	2.25	5.25
2.35	Codes Reported Together 75% or M	October 2012	000	2.35	5.82
Deleted from CPT	CMS High Expenditure Procedural C	January 2012			
Deleted from CPT	CMS High Expenditure Procedural C	September 2011			
Deleted from CPT	CMS High Expenditure Procedural C	January 2012			
Deleted from CPT	CMS High Expenditure Procedural C	January 2012			
1.80	Final Rule for 2015	May 2015	000	1.8	2.89
1.95	Final Rule for 2015	May 2015	000	1.95	5.82
1.55	Final Rule for 2015	May 2015	000	1.55	2.55
1.80	Final Rule for 2015	May 2015	000	1.8	5.88
1.89	Final Rule for 2015	May 2015	000	1.89	2.12
2.20	Final Rule for 2015	May 2015	000	2.2	5.21
1.78	Final Rule for 2015	May 2015	000	1.78	2.31
1.90	Final Rule for 2015	May 2015	000	1.9	5.78
1.95	Different Performing Specialty from	September 2018	000	1.73	5.71
2.25	Different Performing Specialty from	September 2018	000	2.03	7.22
6.05	Site of Service Anomaly	September 2007	010	6.05	NA
4.35	Site of Service Anomaly	September 2007	010	3.55	NA
4.33	Site of Service Anomaly	April 2008	010	4.33	NA
5.65	Site of Service Anomaly	April 2008	010	5	NA
6.10	Site of Service Anomaly	September 2007	010	5.6	NA
4.65	Site of Service Anomaly	September 2007	010	3.93	NA
New PE inputs. 0.48	Different Performing Specialty from	October 2009	XXX	0.48	0.39
New PE inputs. 0.67	Different Performing Specialty from	October 2009	XXX	0.67	0.55
New PE inputs. 0.67	Codes Reported Together 75% or M	October 2010	XXX	0.67	2.09
New PE inputs. 1.10	Codes Reported Together 75% or M	October 2010	XXX	0.9	1.90
Refer to CPT	Pre-Time Analysis / Site of Service A	January 2014	090	13.18	NA
Maintain work RVU and a	Pre-Time Analysis	January 2014	090	18.76	NA

17.95	CMS Request - Final Rule for 2014	November 2013	090	17.95	NA
17.25	CMS Request - Final Rule for 2014	November 2013	090	17.25	NA
15.37	CMS High Expenditure Procedural C	September 2011	090	15.37	NA
3.47	CMS High Expenditure Procedural C	January 2012	ZZZ	3.47	NA
Review action plan at RA\	CMS Fastest Growing / CPT Assistar	October 2008	090	21.86	NA
19.60	Codes Reported Together 95% or M	February 2008	090	19.6	NA
4.04	Codes Reported Together 95% or More		ZZZ	4.04	NA
Review action plan and a(	Codes Reported Together 75% or M	January 2015	090	30.93	NA
15.50	CMS Request - 2009 Final Rule	NA	090	15.6	NA
4.00	CMS Request - 2009 Final Rule	NA	ZZZ	4	NA
7.20. New PE Inputs	Site of Service Anomaly / CMS Fast(	September 2007	010	7.15	58.56
11.43	CMS Fastest Growing	October 2008	090	10.92	NA
Deleted from CPT	Site of Service Anomaly / CMS Fast(	September 2007			
5.03	Site of Service Anomaly / CMS Fastest Growing		010	5.08	14.23
10.87	Site of Service Anomaly / CMS Fastest Growing		090	11	NA
70	Site of Service Anomaly / CMS Fastest Growing		010	7.75	17.85
11.39	Site of Service Anomaly / CMS Fastest Growing		090	11.52	NA
Refer to CPT Assistant. Re	Site of Service Anomaly / CMS Fast(	September 2007	010	5.19	NA
5.25	Site of Service Anomaly	September 2007	010	5.3	NA
0.94	CMS 000-Day Global Typically Repo	July 2016	000	0.94	1.04
Deleted from CPT	High Volume Growth2	April 2013			
Refer to CPT for bundling	CMS Fastest Growing	October 2008	000	1.35	1.89
Refer to CPT for bundling	Site of Service Anomaly / High Volu	September 2007	000	1.48	NA
Refer to CPT	part of New/Revised Review	October 2018	000	1.27	2.76
1.10	Harvard Valued - Utilization over 3(	October 2015	000	1.1	1.38
1.48	CMS Fastest Growing	October 2008	000	1	2.68
Refer to CPT for bundling	Site of Service Anomaly / High Volu	February 2008	000	1.36	NA
Refer to CPT for bundling	CMS Fastest Growing	October 2008	000	1.1	1.45
Refer to CPT for Bundling	Site of Service Anomaly / High Volu	February 2008	000	1.41	NA
1.81	Site of Service Anomaly	September 2007	000	1.27	NA
0.75	Harvard Valued - Utilization over 1(	October 2009	000	0.75	1.45
0.75	High Volume Growth4 / CMS 000-D	October 2016	000	0.75	0.62
CPT Assistant article publ	New code for CPT 2016.	April 2015	000	1.75	2.05
CPT Assistant article publ	New code for CPT 2016.	April 2015	ZZZ	1.1	0.99
CPT Assistant article publ	New code for CPT 2016.	April 2015	000	1.9	4.59
Deleted from CPT	High Volume Growth1	April 2008			
Deleted from CPT	High Volume Growth1	February 2008			
Deleted from CPT	High Volume Growth1	April 2008			
Deleted from CPT	High Volume Growth1	April 2008			
2.29	CMS Fastest Growing	October 2008	000	2.29	5.38
1.20	CMS Fastest Growing	October 2008	ZZZ	1.2	2.66
1.90	CMS Fastest Growing	October 2008	000	1.9	5.26
1.00	CMS Fastest Growing	October 2008	ZZZ	1	2.19
1.82	High Volume Growth1		000	1.82	3.71
1.16	High Volume Growth1		ZZZ	1.16	1.60
1.16	High Volume Growth1		ZZZ	1.16	1.61
1.52	High Volume Growth1		000	1.52	3.58

1.00	High Volume Growth1		ZZZ	1	1.59
1.00	High Volume Growth1		ZZZ	1	1.59
New PE inputs	CMS Request - Practice Expense Re	April 2009	000	1.22	3.00
PE Review - no change	CMS Request - Practice Expense Re	April 2009	000	1.35	5.34
Deleted from CPT	Final Rule for 2015	January 2017			
6.13	Final Rule for 2015	July 2014	010	6.13	64.69
5.76. Article published Jar	High Volume Growth1 / CMS Faste	February 2008	010	5.76	58.65
5.44. 99214 visit appropri	CMS Fastest Growing / High Volum	October 2008	010	5.44	16.70
Deleted from CPT	Final Rule for 2015	January 2017			
0.60	CMS Request - Final Rule for 2014 /	July 2013	000	0.6	3.05
11.19	Site of Service Anomaly		090	9	NA
Deleted from CPT	Site of Service Anomaly	September 2007			
12.20. 99214 visit approp	Site of Service Anomaly / High Leve	September 2007	090	12.2	NA
	Harvard-Valued Annual Allowed Ch	October 2012	010	2.45	5.24
Maintain	High Volume Growth6	October 2019	010	1.85	2.08
PE Review - no change	CMS Request - Practice Expense Re	April 2008			
Deleted from CPT	High Volume Growth1, Harvard Val	February 2008			
PE Review - no change	CMS Request - Practice Expense Re	April 2008			
Deleted from CPT	High Volume Growth1/ CMS Fastes	April 2008			
3.42	Work Neutrality Review	September 2014	010	3.84	8.33
1.32	Work Neutrality Review	September 2014	ZZZ	1.32	4.21
3.42	Work Neutrality Review	September 2014	010	3.78	8.28
1.16	Work Neutrality Review	September 2014	ZZZ	1.16	3.89
1.23. Remove 99238.	Site of Service Anomaly (99238-Onl	September 2007	010	1.98	5.34
6.36	Site of Service Anomaly	September 2007	090	6.36	NA
Remove from screen	Site of Service Anomaly	September 2007	090	8.07	NA
9.16	Site of Service Anomaly	September 2007	090	9.16	NA
Reduce 99238 to 0.5	Site of Service Anomaly (99238-Onl	September 2007	090	9.93	NA
0.49	CMS 000-Day Global Typically Repo	July 2016	000	0.49	0.33
0.75	CMS 000-Day Global Typically Repo	July 2016	000	0.61	0.49
0.93	Harvard Valued - Utilization over 3(	April 2011	000	0.84	1.09
16.00	Site of Service Anomaly	September 2007	090	15.36	NA
8.80	CMS Fastest Growing / 090-Day Glc	October 2008	090	7.81	NA
1.53	Harvard Valued - Utilization over 3(	September 2011	000	1.53	1.82
Deleted from CPT	Harvard Valued - Utilization over 3(	April 2011			
3.00	010-Day Global Post-Operative Visi	January 2014	010	3	3.96
13.94	090-Day Global Post-Operative Visi	January 2014	090	13.94	NA
14.81	090-Day Global Post-Operative Visi	January 2014	090	14.84	NA
8.53	New Technology/ New Service	April 2010	090	12.85	NA
10.25	New Technology/ New Service	October 2020	090	13.6	NA
14.00	Harvard-Valued Annual Allowed Ch	January 2014	090	14	NA
Maintain. 15.00	Harvard-Valued Annual Allowed Ch	October 2012	090	15	NA
Maintain. 13.20	Harvard-Valued Annual Allowed Ch	January 2014	090	13.2	NA
9.58	Harvard-Valued Annual Allowed Ch	January 2014	090	9.58	NA
Maintain. 10.58	Harvard-Valued Annual Allowed Ch	October 2012	090	10.58	NA
6.36	Codes Reported Together 75%or M	October 2017	090	5.62	NA
Maintain. 3.00	High IWPUT / 010-Day Global Post-	February 2008	010	3	5.56

Maintain	MPC List	October 2010	090	3.42	6.06
10.25	High IWPUT / CMS Fastest Growing	September 2007	090	10.25	NA
Contractor Price	Codes Reported Together 75%or M	January 2019	090	0	0.00
7.35	High IWPUT / MPC List / Codes Rep	February 2008	090	7.35	NA
13.15	Codes Reported Together 75%or M	January 2019	090	0	0.00
10.25	Codes Reported Together 75%or M	January 2019	090	0	0.00
12.13	High Volume Category III Codes	January 2021			
9.23	High Volume Category III Codes	January 2021			
1.44	High Volume Growth1 / CMS Faste	February 2008	000	1.44	1.75
12.13	Harvard-Valued Annual Allowed Ch	October 2012	090	12.13	NA
Deleted from CPT	Site of Service Anomaly	September 2007			
13.20	Site of Service Anomaly (99238-Onl	September 2007	090	13.2	NA
14.50	Site of Service Anomaly (99238-Onl	September 2007	090	14.5	NA
16.33	Harvard-Valued Annual Allowed Ch	October 2012	090	16.33	NA
16.33	Harvard-Valued Annual Allowed Ch	October 2012	090	16.33	NA
17.40	Harvard-Valued Annual Allowed Ch	October 2012	090	17.4	NA
3.50	090-Day Global Post-Operative Visi	April 2015	010	3.5	5.95
3.84	090-Day Global Post-Operative Visi	April 2015	010	3.39	4.98
16.00. Reduce 99238 to 0	Site of Service Anomaly (99238-Onl	September 2007	090	16	NA
17.13	Site of Service Anomaly (99238-Onl	September 2007	090	17.13	NA
10.25. Remove 99238	Site of Service Anomaly (99238-Onl	September 2007	090	10.25	14.89
Deleted from CPT	090-Day Global Post-Operative Visi	April 2014			
19.00	090-Day Global Post-Operative Visi	January 2014	090	19	NA
2.53	Harvard Valued - Utilization over 3(	January 2020	090	6.15	8.63
2.53	Harvard Valued - Utilization over 3(	October 2019	090	6.32	8.51
6.36	High IWPUT	February 2008	090	6.36	8.14
6.36	High IWPUT	February 2008	090	6.36	8.62
0.47	New Technology	September 2007	ZZZ	0.47	0.34
Remove from screen	High IWPUT	February 2008	010	4.39	5.16
10.17	Harvard-Valued Annual Allowed Ch	January 2014	090	8.38	NA
5.93	ZZZ Global Post-Operative Visits	April 2020	090	7.77	NA
9.50	ZZZ Global Post-Operative Visits	April 2020	090	9.66	NA
5.93	ZZZ Global Post-Operative Visits	April 2020	090	8.79	NA
10.31	ZZZ Global Post-Operative Visits	April 2020	090	10.93	NA
9.80	ZZZ Global Post-Operative Visits	April 2020	090	9.12	NA
3.00	ZZZ Global Post-Operative Visits	October 2019	ZZZ	5.4	NA
2.00	ZZZ Global Post-Operative Visits	October 2019	ZZZ	5.13	NA
3.50	ZZZ Global Post-Operative Visits	October 2019	ZZZ	5.56	NA
2.06	ZZZ Global Post-Operative Visits	October 2019	ZZZ	5.05	NA
3.23	ZZZ Global Post-Operative Visits	October 2019	ZZZ	2.49	NA
5.00	ZZZ Global Post-Operative Visits	October 2019	ZZZ	6	NA
1.18	CMS 000-Day Global Typically Repo	October 2017	000	1.18	0.91
1.18	CMS 000-Day Global Typically Repo	October 2017	000	1.18	1.26
0.84	CMS 000-Day Global Typically Repo	July 2016	000	0.75	0.69
0.32	CMS High Expenditure Procedural (	July 2015	000	0.32	0.27
3.75	Harvard-Valued Annual Allowed Ch	October 2012	090	3.75	10.51
2.03	Harvard-Valued Annual Allowed Ch	October 2012	090	2.03	7.26

5.48	Harvard-Valued Annual Allowed Ch	October 2012	090	5.48	12.24
5.93	Harvard-Valued Annual Allowed Ch	October 2012	090	5.93	12.07
3.47	Harvard-Valued Annual Allowed Ch	October 2012	090	3.47	10.56
2.03	Harvard-Valued Annual Allowed Ch	October 2012	090	2.03	6.95
5.48	Harvard-Valued Annual Allowed Ch	October 2012	090	5.48	12.25
5.93	Harvard-Valued Annual Allowed Ch	October 2012	090	5.93	12.90
Revised parenthetical	High Volume Growth1	February 2008	000	0.85	0.91
0.49	Harvard Valued - Utilization over 3(	April 2011	000	0.49	0.68
1.00	010-Day Global Post-Operative Visi	January 2014	010	0.82	1.91
1.54	Site of Service Anomaly / 010-Day (	September 2007	010	1.54	3.07
2.03	010-Day Global Post-Operative Visi	September 2014	010	1.74	NA
3.00	010-Day Global Post-Operative Visi	January 2014	010	2.7	8.61
2.35	010-Day Global Post-Operative Visi	September 2014	010	2.1	23.29
0.81	CMS Fastest Growing	October 2008	000	0.81	2.01
0.77	Harvard Valued - Utilization over 3(	April 2011	000	0.77	1.51
0.58.	CMS High Expenditure Procedural (	September 2011	000	0.61	0.69
Deleted from CPT	High Volume Growth2	October 2013			
Deleted from CPT	High Volume Growth2	April 2013			
Deleted from CPT	High Volume Growth2	October 2013			
1.57	Harvard Valued - Utilization over 3(	April 2011	010	1.57	4.15
Review action plan at RA\	CMS Fastest Growing / Site of Serv	September 2007	000	2.06	4.22
Deleted from CPT	CMS Fastest Growing / Site of Service Anomaly (99238-Only)				
17.60	Site of Service Anomaly	September 2007	090	17.73	NA
0.18	CMS-Other - Utilization over 20,00(	January 2019	XXX	0.18	0.74
RUC to submit letter to C	High Volume Growth2	April 2013	XXX	0.18	0.92
0.20	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.17	0.75
0.22	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.22	0.86
0.20	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.18	0.84
0.29	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.28	1.01
RUC to submit letter to C	High Volume Growth2	April 2013	XXX	0.16	0.95
0.20	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.18	0.72
CPT Assistant article publ	Codes Reported Together 75% or M	October 2012	XXX	0.84	2.31
CPT Assistant article publ	Codes Reported Together 75% or M	October 2012			
0.85	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.85	2.43
1.13	CMS High Expenditure Procedural (	April 2013	XXX	1.13	3.49
1.27	Harvard Valued - Utilization over 1(	October 2009	XXX	1.27	4.17
1.28	CMS-Other - Utilization over 30,00(	October 2017	XXX	1.28	3.64
1.13	CMS-Other - Utilization over 30,00(	October 2017	XXX	1.13	4.56
1.27	CMS-Other - Utilization over 30,00(	October 2017	XXX	1.27	5.42
0.85	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.85	3.13
1.17	CMS-Other - Utilization over 250,0(	April 2014	XXX	1.13	3.62
1.30	CMS-Other - Utilization over 250,0(	April 2014	XXX	1.27	4.56
1.28	CMS High Expenditure Procedural (	July 2015	XXX	1.28	3.38
1.38	CMS High Expenditure Procedural (	July 2015	XXX	1.38	4.41
1.62	CMS High Expenditure Procedural (	July 2015	XXX	1.62	5.37
1.75	High Volume Growth1 / CMS Faste	February 2008	XXX	1.75	6.80
1.75	High Volume Growth1 / CMS Faste	February 2008	XXX	1.75	6.79

1.35	CMS High Expenditure Procedural C	July 2015	XXX	1.35	6.02
1.62	CMS High Expenditure Procedural C	July 2015	XXX	1.62	7.14
2.15	CMS High Expenditure Procedural C	July 2015	XXX	2.15	8.88
1.20	CMS High Expenditure Procedural C	July 2015	XXX	1.2	5.71
1.20	CMS High Expenditure Procedural C	July 2015	XXX	1.2	6.08
1.48	CMS High Expenditure Procedural C	July 2015	XXX	1.48	9.09
1.20	CMS High Expenditure Procedural C	July 2015	XXX	1.2	5.74
1.50	CMS High Expenditure Procedural C	July 2015	XXX	1.5	6.32
1.80	CMS High Expenditure Procedural C	July 2015	XXX	1.8	9.27
1.48	CMS High Expenditure Procedural C	September 2011	XXX	1.48	4.76
1.78	CMS High Expenditure Procedural C	September 2011	XXX	1.78	6.91
2.36	CMS-Other - Utilization over 500,0(	April 2011	XXX	2.29	7.97
Deleted from CPT	Low Value-High Volume / CMS High	October 2010			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	MPC List / CMS High Expenditure P	October 2010			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
0.18	CMS High Expenditure Procedural C	February 2016	XXX	0.18	0.55
0.22	CMS High Expenditure Procedural C	February 2016	XXX	0.22	0.74
0.27	CMS High Expenditure Procedural C	February 2016	XXX	0.27	0.95
0.31	CMS High Expenditure Procedural C	February 2016	XXX	0.31	1.00
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
0.22	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.22	0.83
0.27	CMS-Other - Utilization over 250,0(	October 2015	XXX	0.27	0.94
0.29	CMS-Other - Utilization over 250,0(	October 2015	XXX	0.29	0.97
0.32	CMS-Other - Utilization over 250,0(	October 2015	XXX	0.32	1.19
1.16	CMS Fastest Growing / CMS High E	October 2008	XXX	1.08	3.04
1.38	CMS High Expenditure Procedural C	July 2015	XXX	1.16	4.07
1.24	CMS High Expenditure Procedural C	July 2015	XXX	1.25	4.96
1.16	CMS-Other - Utilization over 30,00(	May 2019	XXX	1.08	3.18
1.82	CMS Fastest Growing / MPC List	October 2008	XXX	1.82	6.91
0.16	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.16	0.54
0.22	Low Value-High Volume / CMS-Oth	October 2010	XXX	0.22	0.91
0.27	Low Value-High Volume / CMS-Oth	October 2010	XXX	0.27	1.25
0.30	Low Value-High Volume / CMS-Oth	October 2010	XXX	0.3	1.49
0.20	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.2	0.73
0.23	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.23	0.89
0.25	CMS-Other - Utilization over 100,0(	October 2016	XXX	0.25	1.03
0.21	CMS-Other - Utilization over 100,0(	October 2016	XXX	0.21	0.78
0.22	Harvard Valued - Utilization over 1(	February 2010	XXX	0.22	0.92
0.26	Harvard Valued - Utilization over 1(	October 2009	XXX	0.26	1.20
0.30	Harvard Valued - Utilization over 1(	February 2010	XXX	0.3	1.49
0.22	Harvard Valued - Utilization over 1(	February 2010	XXX	0.22	0.95

1.07	CMS Fastest Growing	October 2008	XXX	1	3.04
1.22	CMS Fastest Growing	February 2009	XXX	1.22	4.06
1.27	CMS Fastest Growing	February 2009	XXX	1.27	4.94
1.00	CMS Fastest Growing	October 2008	XXX	1	3.03
1.22	CMS Fastest Growing	February 2009	XXX	1.22	4.09
1.27	CMS Fastest Growing	February 2009	XXX	1.27	4.97
1.00	CMS Fastest Growing / CMS-Other	February 2009	XXX	1	3.02
1.22	CMS Fastest Growing / CMS-Other	February 2009	XXX	1.22	4.06
1.27	CMS Fastest Growing / CMS-Other	February 2009	XXX	1.27	4.94
1.48	CMS High Expenditure Procedural C	September 2011	XXX	1.48	4.63
1.78	CMS High Expenditure Procedural C	April 2013	XXX	1.78	7.12
1.48	CMS High Expenditure Procedural C	April 2013	XXX	1.48	4.63
1.78	CMS High Expenditure Procedural C	April 2013	XXX	1.78	7.06
1.48	CMS-Other - Utilization over 500,0(	April 2011	XXX	1.48	4.64
1.78	CMS High Expenditure Procedural C	April 2013	XXX	1.78	6.98
2.29	CMS High Expenditure Procedural C	April 2013	XXX	2.29	8.07
2.29	CMS High Expenditure Procedural C	April 2013	XXX	2.29	8.09
2.29	CMS High Expenditure Procedural C	April 2013	XXX	2.29	8.05
0.17	Low Value-High Volume / Codes Re	October 2010	XXX	0.17	0.62
0.25	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.25	0.95
1.81	High Volume Growth1 / CMS Faste:	February 2008	XXX	1.81	7.69
1.09	Codes Reported Together 95% or M	October 2008	XXX	1.09	3.04
1.16	Codes Reported Together 95% or M	October 2008	XXX	1.16	6.05
1.22	Codes Reported Together 95% or M	February 2008	XXX	1.22	6.81
1.46	CMS High Expenditure Procedural C	July 2015	XXX	1.46	6.02
1.73	CMS High Expenditure Procedural C	July 2015	XXX	1.73	7.04
2.20	CMS High Expenditure Procedural C	July 2015	XXX	2.2	8.83
0.20	CMS-Other - Utilization over 100,0(	October 2016	XXX	0.17	0.77
0.26	CMS-Other - Utilization over 100,0(	October 2016	XXX	0.23	0.89
0.20	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.17	0.75
0.91	Codes Reported Together 75% or M	October 2012	XXX	0.91	2.43
0.91	Codes Reported Together 75% or M	October 2013	XXX	0.91	2.43
0.83	Codes Reported Together 75% or M	October 2012	XXX	0.83	2.29
1.33	Codes Reported Together 75% or M	October 2012	XXX	1.33	2.94
Deleted from CPT	Different Performing Specialty from	October 2009	XXX	0.76	3.29
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
0.16	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.16	0.76
0.17	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.17	0.50
0.15	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.15	0.46
0.18	Low Value-High Volume / CMS-Oth	October 2010	XXX	0.18	0.80
0.18	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.18	0.63
0.16	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.16	0.76
0.16	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.16	0.67
0.17	Harvard Valued - Utilization over 1(	October 2009	XXX	0.17	0.75
0.16	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.16	0.67
0.16	CMS High Expenditure Procedural C	July 2015	XXX	0.16	0.81

0.17	Low Value-High Volume / CMS High	October 2010	XXX	0.17	0.99
0.16	CMS High Expenditure Procedural C	July 2015	XXX	0.16	0.73
0.17	Low Value-High Volume / CMS High	October 2010	XXX	0.17	0.87
0.13	CMS High Expenditure Procedural C	July 2015	XXX	0.13	0.94
1.09	CMS Fastest Growing	October 2008	XXX	1	4.14
Remove from screen	CMS Fastest Growing	February 2009	XXX	1.16	5.25
Remove from screen	CMS Fastest Growing	February 2009	XXX	1.22	6.80
Survey with all CTA codes	CMS Request - Final Rule for 2013	May 2013	XXX	1.81	7.60
CPT Assistant published.	CMS Fastest Growing	October 2008	XXX	1.35	8.72
1.35	CMS Fastest Growing / CMS High E	October 2008	XXX	1.35	5.13
Deleted from CPT	CMS-Other - Utilization over 500,0(	April 2011			
0.17	Codes Reported Together 75% or M	October 2014	XXX	0.18	0.74
0.22	Codes Reported Together 75% or M	October 2014	XXX	0.22	1.12
0.27	Codes Reported Together 75% or M	October 2014	XXX	0.27	1.42
Deleted from CPT	Havard Valued - Utilization over 1 M	October 2008			
Deleted from CPT	CMS-Other - Utilization over 250,0(	April 2013			
0.22	Codes Reported Together 75% or M	October 2014	XXX	0.22	0.96
0.29	Codes Reported Together 75% or M	October 2014	XXX	0.29	1.25
0.31	Codes Reported Together 75% or M	October 2014	XXX	0.31	1.46
Deleted from CPT	Codes Reported Together 75% or M	October 2014			
Deleted from CPT	Different Performing Specialty from	October 2009			
Deleted from CPT	CMS-Other - Utilization over 500,0(	April 2011			
0.16	Codes Reported Together 75% or M	October 2014	XXX	0.16	0.68
0.18	Codes Reported Together 75% or M	October 2014	XXX	0.18	0.83
0.16	Low Value-High Volume	October 2010	XXX	0.16	0.82
0.18	Low Value-High Volume	October 2010	XXX	0.18	0.98
0.22	Low Value-High Volume	October 2010	XXX	0.22	1.10
0.16	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.16	1.01
Refer to CPT	High Volume Growth1 / CMS Faste	February 2008	XXX	0.54	3.68
0.16	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.16	0.74
0.16	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.16	0.77
0.17	Havard Valued - Utilization over 1 M	October 2008	XXX	0.17	0.88
0.16	Low Value-High Volume	October 2010	XXX	0.16	0.65
0.17	Havard Valued - Utilization over 1 M	October 2008	XXX	0.17	0.81
0.16	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.16	0.66
0.13	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.13	0.70
1.00	CMS Fastest Growing	October 2008	XXX	1	3.02
1.16	High Volume Growth1 / CMS-Other	February 2009	XXX	1.16	4.06
1.22	High Volume Growth1	February 2009	XXX	1.22	4.88
Survey for October 2013.	High Volume Growth1	February 2008	XXX	1.9	8.30
1.35	CMS High Expenditure Procedural C	July 2015	XXX	1.35	5.93
1.62	CMS High Expenditure Procedural C	July 2015	XXX	1.62	6.94
2.15	CMS High Expenditure Procedural C	July 2015	XXX	2.15	8.88
1.35	MPC List	October 2010	XXX	1.35	5.11
Deleted from CPT	Low Value-High Volume / CMS High	October 2010			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
0.18	CMS High Expenditure Procedural C	February 2016	XXX	0.18	0.67

0.23	CMS High Expenditure Procedural C	February 2016	XXX	0.23	0.83
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
0.27	CMS High Expenditure Procedural C	February 2016	XXX	0.27	0.96
0.32	CMS High Expenditure Procedural C	July 2015	XXX	0.32	1.11
Review PE. 0.35	Codes Reported Together 95% or M	February 2008	XXX	1.19	3.05
0.42	Codes Reported Together 95% or M	February 2008	XXX	1.27	6.07
1.40	Codes Reported Together 95% or M	February 2008	XXX	1.4	6.85
2.20	Codes Reported Together 75% or More-Part1 / CMS F		XXX	2.2	9.64
1.82	CMS Fastest Growing / Codes Repo	October 2008	XXX	1.82	7.68
1.74	CMS Fastest Growing	October 2009	XXX	1.74	3.91
1.82	CMS Fastest Growing / CMS Reque	October 2009	XXX	1.82	7.79
2.01	CMS Fastest Growing	October 2009	XXX	2.01	8.78
1.46	CMS High Expenditure Procedural C	July 2015	XXX	1.46	4.86
1.73	CMS High Expenditure Procedural C	July 2015	XXX	1.73	8.19
2.20	CMS High Expenditure Procedural C	July 2015	XXX	2.2	8.85
0.59	CMS-Other - Utilization over 100,0(	October 2016	XXX	0.59	2.27
0.60	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.6	2.31
0.70	CMS-Other - Utilization over 30,00(	October 2018	XXX	0.7	2.57
0.53	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.53	3.33
0.80	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.8	2.82
Deleted from CPT	CMS-Other - Utilization over 30,00(	October 2017			
Deleted from CPT	CMS-Other - Utilization over 30,00(	October 2017			
0.90	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.9	3.26
Deleted from CPT	Harvard Valued - Utilization over 3(	April 2011			
0.70	CMS-Other - Utilization over 30,00(	October 2018	ZZZ	0.7	1.75
Deleted from CPT	CMS-Other - Utilization over 30,00(	October 2017			
0.81	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.81	2.82
1.17	CMS-Other - Utilization over 30,00(	October 2017	XXX	1.17	10.69
Deleted from CPT	CMS-Other - Utilization over 30,00(	October 2017			
1.04	CMS-Other - Utilization over 30,00(	October 2017	XXX	1.04	3.56
1.26	Harvard Valued - Utilization over 3(	April 2011	XXX	1.26	5.41
0.32	CMS-Other - Utilization over 30,00(	October 2018	XXX	0	0.00
0.21	CMS-Other - Utilization over 30,00(	October 2018	ZZZ	0	0.00
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	February 2015			
0.47	CMS-Other - Utilization over 30,00(	October 2018	XXX	0	0.00
0.50	CMS-Other - Utilization over 30,00(	October 2018	XXX	0	0.00
0.70	CMS-Other - Utilization over 30,00(	October 2018	XXX	0	0.00
0.49	Harvard Valued - Utilization over 3(	April 2011	XXX	0.49	3.46
0.52	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.52	1.69
0.51, editorially revised	Codes Reported Together 75% or M	October 2012	XXX	0.51	3.53
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
0.83	Codes Reported Together 75% or M	September 2017	XXX	0.83	2.63
Maintain	High Volume Growth7	October 2020	XXX	2.6	9.39
Maintain	High Volume Growth7	October 2020	XXX	1.75	6.13

Maintain	CMS Request - Final Rule for 2013 /	May 2013	XXX	2.4	9.10
1.75	CMS-Other - Utilization over 30,00(	October 2017	XXX	1.44	2.29
2.00	CMS-Other - Utilization over 30,00(	October 2017	XXX	2	2.62
2.40	High Volume Growth1 / CMS High E	February 2008	XXX	2.4	10.42
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Refer to CPT Assistant an(	CMS High Expenditure Procedural (	July 2015	XXX	1.75	2.66
1.97	CMS High Expenditure Procedural (	July 2015	XXX	1.97	2.79
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
2.05	CMS-Other - Utilization over 30,00(	October 2017	XXX	2.05	3.00
1.01	CMS-Other - Utilization over 30,00(	October 2017	ZZZ	1.01	1.93
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or More				
1.05	CMS-Other - Utilization over 20,00(	January 2019	XXX	1.05	2.30
1.48	CMS-Other - Utilization over 20,00(	October 2019	XXX	1.48	2.51
New PE inputs	CMS Request - Practice Expense Re	NA	XXX	1.44	2.64
New PE inputs	CMS Request - Practice Expense Re	NA	XXX	1.44	2.68
Maintain	Codes Reported Together 75% or M	February 2010	XXX	0	0.00
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Refer to CPT Assistant	Codes Reported Together 75% or M	February 2010	XXX	0	0.00
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Final Rule for 2015	July 2014			
Deleted from CPT	Final Rule for 2015	July 2014			
Deleted from CPT	Codes Reported Together 75%or M	October 2015			
Deleted from CPT	Codes Reported Together 75%or M	October 2015			
Deleted from CPT	Codes Reported Together 75%or M	January 2017			
Deleted from CPT	High Volume Growth1 / Codes Reported Together 75% or More-Part1				
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	High Volume Growth1 / Codes Rep(	April 2010			
Deleted from CPT	High Volume Growth1				
Deleted from CPT	Codes Reported Together 75% or M	January 2015			
Deleted from CPT	Codes Reported Together 75% or M	January 2015			
Deleted from CPT	CMS-Other - Utilization over 250,0(	April 2013			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
0.83	Codes Reported Together 75% or M	October 2012	XXX	0.83	2.17
Deleted from CPT	High Volume Growth1	February 2008			
Deleted from CPT	High Volume Growth1	February 2008			
Deleted from CPT	High Volume Growth1	April 2008			
Deleted from CPT	High Volume Growth1	April 2008			
Deleted from CPT	High Volume Growth1	April 2008			
0.30	Low Value-Billed in Multiple Units /	October 2010	XXX	0.3	0.90
Deleted from CPT	CMS-Other - Utilization over 100,0(	October 2016			
0.31	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.31	0.89
New PE inputs	CMS Request - Practice Expense Re	April 2009	XXX	0.58	2.12

New PE inputs	CMS Request - Practice Expense Re	April 2009	XXX	0.58	2.30
New PE inputs	CMS Request - Practice Expense Re	April 2009	XXX	0.58	4.65
0.20	Negative IWPUT	April 2017	XXX	0.2	0.44
Refer to CPT	CMS Request - Final Rule for 2020	July 2019	XXX	0.79	1.24
0.70	CMS High Expenditure Procedural C	April 2016	XXX	0.7	1.41
0.64	CMS High Expenditure Procedural C	April 2016	XXX	0.64	1.02
0.56	CMS High Expenditure Procedural C	July 2015	XXX	0.56	0.85
0.60 and CPT Assistant ar	High Volume Growth1 / CPT Assista	February 2008	XXX	0.6	1.67
0.17	Negative IWPUT	April 2017	XXX	0.14	0.18
0.40	CMS High Expenditure Procedural C	April 2016	XXX	0.4	0.94
0.54	CMS High Expenditure Procedural C	July 2015	XXX	0.54	1.40
0.56	CMS Fastest Growing	October 2008	XXX	0.56	2.81
0.59	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.59	1.32
0.73	CMS-Other - Utilization over 500,0(	January 2014	XXX	0.73	2.34
0.68	CMS-Other - Utilization over 500,0(	January 2014	XXX	0.68	1.84
Deleted from CPT	CMS-Other - Utilization over 500,0(	April 2011			
0.81	MPC List	October 2010	XXX	0.81	2.71
0.59	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.59	2.03
0.55	Final Rule for 2015	May 2015	XXX	0.55	2.62
0.74	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.74	2.51
0.58	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.58	1.09
Remove from screen	High Volume Growth2	April 2013	XXX	0.77	1.71
0.69	CMS High Expenditure Procedural C	September 2011	XXX	0.69	2.90
0.69	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.69	2.48
0.50	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.5	0.87
0.64	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.64	2.39
0.69	CMS High Expenditure Procedural C	September 2011	XXX	0.69	4.79
Deleted from CPT	CMS Fastest Growing	October 2008			
Revised PE. RAW review i	CMS Fastest Growing / New Techn(	April 2010	XXX	0.63	1.28
Revised PE. RAW review i	CMS Fastest Growing / New Techn(	April 2010	XXX	0.49	1.13
Deleted from CPT	CMS Request - Final Rule for 2014	July 2013			
0.67	CMS Request - Final Rule for 2014	July 2013	YYY	0	0.00
Maintain	CMS Request - Final Rule for 2014	July 2013	XXX	1.99	5.68
Review in 2 years (Oct 20	Identified in RUC review of other se	January 2018	ZZZ	0.3	0.80
2.00	CMS Request - Final Rule for 2014	July 2013	YYY	0	0.00
Refer to CPT. 0.67	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.67	0.97
0.85	CMS Request - Final Rule for 2014	July 2013	XXX	0.67	1.65
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Maintain	CMS Request - Final Rule for 2014	July 2013	XXX	1.34	1.31
Deleted from CPT	High Volume Growth1 / CMS-Other	February 2008	XXX		
Refer to CPT	CMS-Other - Utilization over 20,00(	January 2019	XXX	0	0.00
0.38	MPC List / CMS Request - Final Rule	January 2012	ZZZ	0.38	2.58
0.54	MPC List / CMS Request - Final Rule	January 2012	ZZZ	0.54	2.82
0.60	MPC List / CMS Request - Final Rule	October 2010	ZZZ	0.6	2.42
New PE inputs	CMS Request - Practice Expense Review		XXX	1.21	5.59
Bundled 32405 and 7701	CMS-Other - Utilization over 100,0(	April 2016	XXX	1.5	2.73
Referred to CPT, but CMS	CMS Request - Practice Expense Re	October 2010	XXX	0.85	2.72

Deleted from CPT	Codes Reported Together 75% or M	January 2012			
Deleted from CPT	Codes Reported Together 75% or M	January 2012			
1.45	CMS High Expenditure Procedural C	June 2017	XXX	1.45	5.44
1.60	CMS High Expenditure Procedural C	June 2017	XXX	1.6	5.48
2.10	CMS High Expenditure Procedural C	June 2017	XXX	2.1	8.88
2.30	CMS High Expenditure Procedural C	June 2017	XXX	2.3	8.91
Deleted from CPT	CMS-Other - Utilization over 250,000 / Final Rule for 2015				
Deleted from CPT	Low Value-High Volume	October 2010			
Deleted from CPT	CMS-Other - Utilization over 250,0(	January 2014			
Deleted from CPT	CMS-Other - Utilization over 250,0(	January 2014			
Deleted from CPT	CMS-Other - Utilization over 250,0(	January 2014			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
0.81	Final Rule for 2015	October 2015	XXX	0.81	2.90
1.00	Final Rule for 2015	October 2015	XXX	1	3.70
0.76	Final Rule for 2015	October 2015	XXX	0.76	3.04
0.26	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.26	1.03
0.44	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.44	1.43
0.55	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.55	2.29
0.70	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.7	2.36
0.33	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.33	1.01
Deleted from CPT	Different Performing Specialty from	October 2009			
0.20	CMS Request - Final Rule for 2012 /	September 2011	XXX	0.2	0.89
0.20	Negative IWPUT	April 2017	XXX	0.2	0.70
Deleted from CPT	CMS Request - Final Rule for 2012 /	September 2011			
Deleted from CPT	Different Performing Specialty from	October 2009			
0.30	Codes Reported Together 75% or More-Part2		XXX	0.3	1.21
0.17	Codes Reported Together 75% or More-Part2		XXX	0.17	0.79
1.30	CMS High Expenditure Procedural C	July 2015	XXX	1.3	0.67
2.00	CMS High Expenditure Procedural C	July 2015	XXX	2	0.99
3.14	CMS High Expenditure Procedural C	July 2015	XXX	3.14	1.51
0.70	Harvard Valued - Utilization over 3(	April 2011	XXX	0.7	7.55
1.05	Harvard Valued - Utilization over 3(	September 2011	XXX	1.05	12.64
1.56	MPC List / Harvard Valued - Utilizat	October 2010	XXX	1.56	12.74
2.00	Harvard Valued - Utilization over 30,000		ZZZ	2	10.91
4.29	Harvard Valued - Utilization over 3(	September 2011	XXX	4.29	9.58
0.62	MPC List / Codes Reported Togethe	October 2010	XXX	0.62	1.28
New PE Inputs. 7.99. CPT	CMS Fastest Growing / CMS Reque:	October 2008	XXX	7.99	46.91
Deleted from CPT	Codes Reported Together 75% or M	October 2010			
1.40	Codes Reported Together 75% or M	October 2010	XXX	1.4	2.84
2.90	Codes Reported Together 75% or M	October 2010	XXX	2.9	5.33
Deleted from CPT	Codes Reported Together 75% or M	October 2010			
Deleted from CPT	Codes Reported Together 75% or M	October 2010			
1.50	Codes Reported Together 75% or M	October 2012	XXX	1.4	5.29
1.83	Codes Reported Together 75% or M	October 2012	XXX	1.83	6.96
2.90	Codes Reported Together 75% or M	October 2012	XXX	2.9	9.61
Deleted from CPT	Codes Reported Together 75% or M	October 2012			

Deleted from CPT	Codes Reported Together 75% or M	October 2010			
Deleted from CPT	Codes Reported Together 75% or M	October 2012			
0.54	CMS High Expenditure Procedural C	April 2015	XXX	0.45	0.74
0.84	CMS High Expenditure Procedural C	April 2015	XXX	0.75	3.09
1.24	MPC List / RUC request / CMS High	October 2010	XXX	1.15	2.47
New PE Inputs	CMS Request - Final Rule for 2013	October 2012	XXX	0	2.31
New PE Inputs	Services with Stand-Alone PE Proce	October 2012	XXX	4.29	9.27
New PE inputs	CMS Request - Practice Expense Re	NA	XXX	0	0.00
New PE Inputs	Services with Stand-Alone PE Procedure Time		XXX	0	30.62
New PE inputs	Services with Stand-Alone PE Proce	July 2012	XXX	0	33.38
PE Only, revised introduct	Services with Stand-Alone PE Proce	January 2014	XXX	0	0.00
PE Only, revised introduct	Services with Stand-Alone PE Proce	January 2014	XXX	0	0.00
0.58	Services with Stand-Alone PE Proce	January 2014	XXX	0	0.00
New PE Inputs	High Volume Growth5	October 2018	XXX	0	1.25
PE Only, revised introduct	Services with Stand-Alone PE Proce	October 2012	XXX	0	0.00
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
PE Only, revised introduct	Services with Stand-Alone PE Proce	October 2012	XXX	0	0.00
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
PE Only, revised introduct	Services with Stand-Alone PE Proce	October 2012	XXX	0	0.00
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
Deleted from CPT	CMS Fastest Growing / Services wit	October 2008			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Contractor Price	CMS Request - Final Rule for 2015	November 2014			
Contractor Price	CMS Request - Final Rule for 2015	November 2014	XXX	0	0.00
3.45. Remove from high E	Site of Service Anomaly / High Leve	September 2007	XXX	3.37	1.88
Remove from screen	High Volume Growth4	October 2016	XXX	11.87	5.81
2.03	CMS High Expenditure Procedural C	July 2015	XXX	2.03	1.73
New PE Inputs	Contractor Priced High Volume	October 2018	XXX	0	0.00
New PE Inputs	Contractor Priced High Volume	January 2018	XXX	0	0.00
New PE Inputs	High Volume Growth4 / Contractor	October 2016	XXX	0	0.00
New PE Inputs	Contractor Priced High Volume	October 2018	XXX	0	0.00
New PE Inputs	Services with Stand-Alone PE Proce	October 2012	XXX	1.31	12.92
1.05	Codes Reported Together 75% or M	October 2014	XXX	1.05	6.09
1.40	Codes Reported Together 75% or M	October 2014	XXX	1.4	9.17
1.95	Codes Reported Together 75% or M	October 2014	XXX	1.95	8.07
3.80	Codes Reported Together 75% or M	October 2014	XXX	3.8	13.63
5.40	Codes Reported Together 75% or M	October 2014	XXX	5.4	20.66
Deleted from CPT	Codes Reported Together 75% or M	February 2015			
Deleted from CPT	Codes Reported Together 75% or M	February 2015			
8.78	Codes Reported Together 75% or M	October 2012	000	8.78	16.56
Deleted from CPT	CMS Fastest Growing	October 2008			

Deleted from CPT	High Volume Growth1 / CMS Faste	February 2008			
Deleted from CPT	CMS Fastest Growing	February 2008			
Deleted from CPT	High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Se				
Deleted from CPT	High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Se				
Deleted from CPT	High Volume Growth1 / CMS Faste	October 2012			
0.00	Codes Reported Together 75% or M	October 2012	XXX	0	0.44
Deleted from CPT	Harvard Valued - Utilization over 30,000				
Deleted from CPT	Harvard Valued - Utilization over 30,000				
Deleted from CPT	Harvard Valued - Utilization over 30,000				
Deleted from CPT	Harvard Valued - Utilization over 30,000				
Deleted from CPT	Harvard Valued - Utilization over 3(	April 2011			
Deleted from CPT	Harvard Valued - Utilization over 30,000				
Deleted from CPT	Harvard Valued - Utilization over 30,000				
0.19	Harvard Valued - Utilization over 30,000		XXX	0.19	2.16
0.37	Harvard Valued - Utilization over 30,000		XXX	0.37	5.33
0.50	Harvard Valued - Utilization over 30,000		XXX	0.5	6.47
0.80	Harvard Valued - Utilization over 3(	April 2011	XXX	0.8	7.80
1.20	Harvard Valued - Utilization over 3(	April 2011	XXX	1.2	9.06
1.60	Harvard Valued - Utilization over 3(	April 2011	XXX	1.6	11.34
Deleted from CPT	Harvard Valued - Utilization over 1(	October 2009			
0.74	Harvard Valued - Utilization over 100,000		XXX	0.74	8.80
0.90	Harvard Valued - Utilization over 100,000		XXX	0.9	11.97
CPT Assistant article publ	New code for CPT 2016.	April 2015	XXX	0.98	10.46
CPT Assistant article publ	New code for CPT 2016.	April 2015	XXX	1.08	11.62
0.99	Harvard Valued - Utilization over 3(	April 2011	XXX	0.99	9.16
0.62	CMS High Expenditure Procedural (	July 2015	XXX	0.62	6.06
0.83	CMS High Expenditure Procedural (	July 2015	XXX	0.83	7.27
0.86	CMS High Expenditure Procedural (	July 2015	XXX	0.86	7.86
1.76	High Volume Growth4	May 2018	XXX	0	0.00
1.67	High Volume Growth4	May 2018	XXX	0	0.00
1.90	High Volume Growth4	May 2018	XXX	0	0.00
2.07	High Volume Growth4	May 2018	XXX	0	0.00
2.26	High Volume Growth4	May 2018	XXX	0	0.00
0.63	High Volume Growth4	May 2018	ZZZ	0	0.00
1.40	Codes Reported Together 95% or M	NA	XXX	1.38	8.53
1.75	Codes Reported Together 95% or M	NA	XXX	1.62	12.21
1.00	Codes Reported Together 95% or M	NA	XXX	1	7.72
1.34	Codes Reported Together 95% or M	NA	XXX	1.34	11.29
1.61	High Volume Growth4	May 2018	XXX	0	0.00
Deleted from CPT	Codes Reported Together 95% or More				
Deleted from CPT	Codes Reported Together 95% or More				
Deleted from CPT	Codes Reported Together 95% or More				
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
0.98	Harvard Valued - Utilization over 3(	April 2011	XXX	0.98	5.64
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
1.56	High Volume Growth4	May 2018	XXX	0	0.00

1.80	High Volume Growth4	October 2016	XXX	0	0.00
0.49	Harvard Valued - Utilization over 1(	February 2010	XXX	0.49	4.95
0.74	Harvard Valued - Utilization over 1(	February 2010	XXX	0.74	6.14
1.07	Harvard Valued - Utilization over 1(	February 2010	XXX	1.07	8.63
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
Deleted from CPT	Harvard Valued - Utilization over 1(	October 2009			
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
0.75	Harvard Valued - Utilization over 1(	February 2010	XXX	0.75	5.12
0.85	Harvard Valued - Utilization over 1(	February 2010	XXX	0.85	8.01
1.20	Harvard Valued - Utilization over 3(	January 2016	XXX	1.09	10.20
Reaffirmed RUC recomme	MPC List	October 2010	XXX	0	0.00
Article published Feb 201	Different Performing Specialty from	October 2009	XXX	1.96	2.28
Deleted from CPT	CMS-Other - Utilization over 20,00(	January 2019	XXX	0.37	0.25
Deleted from CPT	CMS-Other - Utilization over 20,00(	January 2021	XXX	1.33	0.69
0.50	CMS-Other - Utilization over 20,00(	January 2021			
0.91	CMS-Other - Utilization over 20,00(	January 2021			
1.80	CMS-Other - Utilization over 20,00(	January 2021			
0.80	CMS-Other - Utilization over 20,00(	January 2021			
0.45	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.45	NA
1.00	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.94	1.01
0.75	Negative IWPUT	April 2017	XXX	0	0.00
New PE Inputs. 0.56	Harvard Valued - Utilization over 1(	October 2009	XXX	0.56	1.35
New PE Inputs. 0.56	Harvard Valued - Utilization over 1(	February 2010	XXX	0.37	1.53
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
New PE Inputs. 0.56	Harvard Valued - Utilization over 1(	February 2010	XXX	0.44	1.37
New PE Inputs. 0.56	CMS High Expenditure Procedural (	September 2011	XXX	0.56	1.36
Utilization shift is appropi	CMS Request - Final Rule for 2013	November 2012	XXX	1.2	16.90
Utilization shift is appropi	CMS Request - Final Rule for 2013	November 2012	XXX	1	12.06
0.42	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.26	0.36
New PE Inputs	CMS Request - Final Rule for 2015	April 2015	XXX	0.5	1.54
New PE Inputs	CMS Request - Final Rule for 2015	April 2015	XXX	0.5	1.54
New PE Inputs	CMS Request - Final Rule for 2015	April 2015	XXX	0.76	2.20
New PE Inputs. Removed	CMS High Expenditure Procedural (	July 2015	XXX	0	1.98
New PE Inputs. Removed	CMS High Expenditure Procedural (	July 2015	ZZZ	0	0.66
0.74	CMS High Expenditure Procedural (	July 2015	XXX	0.74	0.27
1.40	CMS High Expenditure Procedural (	July 2015	XXX	1.2	0.55
1.70	CMS High Expenditure Procedural (	July 2015	XXX	1.7	0.65
0.08 and new PE inputs	Havard Valued - Utilization over 1 M	February 2009	XXX	0.08	0.35
0.13 and new PE inputs	Havard Valued - Utilization over 1 M	February 2009	XXX	0.13	0.77
0.22 and new PE inputs	Havard Valued - Utilization over 1 M	October 2008	XXX	0.22	0.97
0.75 and new PE inputs	Havard Valued - Utilization over 1 M	October 2008	XXX	0.75	1.28

1.59 and new PE inputs	Havard Valued - Utilization over 1 M	February 2009	XXX	1.59	6.65
2.80 and new PE inputs	Havard Valued - Utilization over 1 M	February 2009	XXX	2.8	9.77
0.54	Havard Valued - Utilization over 1 M	October 2008	XXX	0.54	2.68
0.24	Havard Valued - Utilization over 1 M	October 2008	XXX	0.24	2.08
0.45	Havard Valued - Utilization over 1 M	February 2009	XXX	0.45	2.44
Deleted from CPT	Havard Valued - Utilization over 1 Million				
0.53	Havard Valued - Utilization over 1 Million		XXX	0.53	3.17
1.63	CMS High Expenditure Procedural C	July 2015	XXX	1.63	1.12
1.83	CMS High Expenditure Procedural C	July 2015	XXX	1.83	1.43
2.85	CMS High Expenditure Procedural C	July 2015	XXX	2.85	1.79
0.67	Harvard Valued - Utilization over 1C	February 2010	XXX	0.67	0.99
1.19	Harvard Valued - Utilization over 1C	October 2009	XXX	1.19	1.78
0.59	Harvard Valued - Utilization over 1C	October 2009	XXX	0.59	0.97
1.20	CMS Request - Final Rule for 2016	July 2015	XXX	1.2	1.53
0.73	CMS Request - Final Rule for 2016	July 2015	ZZZ	0.73	0.90
0.65	CMS Request - Final Rule for 2014	November 2013	ZZZ	0.56	2.12
0.70	CMS-Other - Utilization over 500,0C	April 2011	XXX	0.7	2.32
Deleted from CPT	CMS Request - Final Rule for 2014	November 2013			
0.77	CMS Request - Final Rule for 2014	November 2013	XXX	0.77	4.32
0.74	CMS-Other - Utilization over 250,0C	April 2013	XXX	0.74	3.42
Deleted from CPT	CMS-Other - Utilization over 250,0C	October 2013			
New PE Inputs	Services with Stand-Alone PE Proce	October 2012	XXX	1.51	10.80
Deleted from CPT	Services with Stand-Alone PE Proce	October 2012			
0.70	CMS-Other - Utilization over 250,0C	October 2014	ZZZ	0.59	2.56
2.80	High Volume Growth2	April 2013	XXX	2.8	4.11
0.85	CMS High Expenditure Procedural C	July 2015	XXX	0.85	2.71
0.95	CMS High Expenditure Procedural C	July 2015	XXX	0.95	2.59
0.88	CMS Request - Final Rule for 2014	November 2013	ZZZ	0.7	3.42
0.88	CMS Request - Final Rule for 2012 /	September 2011	XXX	0.88	4.41
1.24	CMS Request - Final Rule for 2012 /	May 2013	XXX	1.24	7.13
0.86	CMS Request - Final Rule for 2012 /	September 2011	XXX	0.73	2.57
0.88	CMS Request - Final Rule for 2012 /	September 2011	XXX	0.88	3.02
0.86	CMS Request - Final Rule for 2014	November 2013	ZZZ	0.58	1.51
1.04	CMS Request - Final Rule for 2014		XXX	0.93	9.15
1.40	CMS Request - Final Rule for 2012 /	May 2013	XXX	1.4	10.73
New PE inputs	CMS Request - Practice Expense Re	NA			
New PE inputs	CMS Request - Practice Expense Re	NA			
New PE inputs	CMS Request - Practice Expense Re	February 2008	XXX	0.17	0.31
New PE inputs	CMS Request - Practice Expense Re	February 2008	ZZZ	0.15	0.21
New PE inputs	CMS Request - Practice Expense Re	NA	XXX	0.17	0.31
New PE inputs	CMS Request - Practice Expense Re	NA	ZZZ	0.15	0.21
Refer to CPT Review in 3	CMS High Expenditure Procedural C	April 2013	ZZZ	0.33	0.09
3.00	CMS High Expenditure Procedural C	April 2013	XXX	3.84	1.20
3.25	CMS High Expenditure Procedural C	April 2013	XXX	4.16	1.47
Deleted from CPT	CMS High Expenditure Procedural C	September 2011			
Deleted from CPT	CMS High Expenditure Procedural C	September 2011			
Deleted from CPT	CMS High Expenditure Procedural C	September 2011			

Deleted from CPT	CMS High Expenditure Procedural C	September 2011			
Deleted from CPT	CMS High Expenditure Procedural C	September 2011			
1.50	CMS High Expenditure Procedural C	April 2013	XXX	1.7	0.48
1.50	CMS High Expenditure Procedural C	April 2013	ZZZ	1.5	0.49
2.00	CMS High Expenditure Procedural C	April 2013	XXX	2.24	0.63
1.90	CMS High Expenditure Procedural C	April 2013	ZZZ	1.9	0.62
3.00	CMS High Expenditure Procedural C	April 2013	XXX	3.31	0.93
2.50	CMS High Expenditure Procedural C	April 2013	ZZZ	2.5	0.82
3.13	CMS High Expenditure Procedural C	April 2013	XXX	3.13	0.90
1.50	CMS High Expenditure Procedural C	April 2013	ZZZ	1.5	0.42
2.10	CMS High Expenditure Procedural C	April 2013	XXX	2.1	0.62
2.40	CMS High Expenditure Procedural C	April 2013	XXX	2.4	0.35
2.50	CMS High Expenditure Procedural C	April 2013	XXX	2.5	0.35
0.59	CMS High Expenditure Procedural C	April 2013	XXX	0.59	0.18
Deleted from CPT	CMS High Expenditure Procedural C	September 2011			
0.48	CMS High Expenditure Procedural C	April 2013	XXX	0.48	0.23
Review in 2 years (Oct 20	Contractor Priced High Volume	January 2018	000	0	0.00
2.50	Harvard Valued - Utilization over 1(	October 2009	000	2.5	2.49
Deleted from CPT	Negative IWPUT	April 2017			
0.90	Negative IWPUT	September 2018	000	0.9	1.43
0.50	Negative IWPUT	September 2018	ZZZ	0.5	0.40
1.48	Havard Valued - Utilization over 1 M	October 2008	000	1.48	NA
2.11	Havard Valued - Utilization over 1 M	February 2009	000	2.11	NA
1.56	Havard Valued - Utilization over 1 M	February 2009	000	1.56	NA
2.52	Havard Valued - Utilization over 1 M	February 2009	000	2.52	NA
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	23.92	8.88
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	0	0.00
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	0	0.00
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	15.98	5.66
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	10.32	4.37
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	6.64	3.10
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	15.46	6.19
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	9.87	4.23
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	6.19	2.93
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	6.77	3.20
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	5.52	2.75
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	3.57	2.11
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	12.09	4.93
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	10.25	4.37
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	9.8	4.26
RUC Recommended revis	CMS Request - Practice Expense Re	February 2009	XXX	5.52	2.74
New PE Inputs	CMS Request - Practice Expense Re	February 2010	000	1.1	12.08
2.49	CMS High Expenditure Procedural C	July 2015	XXX	2.49	22.79
1.00	CMS High Expenditure Procedural C	July 2015	XXX	1	26.74
New PE Inputs	CMS Request - Practice Expense Review		XXX	0.52	11.72
New PE Inputs	CMS Request - Practice Expense Review		XXX	0.66	12.25
Refer to CPT	Harvard Valued - Utilization over 3(	October 2019	XXX	0.37	1.17

0.30	Harvard Valued - Utilization over 1(	October 2009	XXX	0.3	0.66
0.40	Harvard Valued - Utilization over 1(	October 2009	XXX	0.4	0.96
0.50	MPC List / CMS High Expenditure P	October 2010	XXX	0.5	1.32
0.61	Harvard Valued - Utilization over 3(	April 2011	XXX	0.61	1.85
0.50	CMS Fastest Growing	October 2009	XXX	0.4	0.66
0.50	CMS Fastest Growing	October 2008	XXX	0.45	0.72
Deleted from CPT	CMS Fastest Growing	October 2008			
0.54	CMS Fastest Growing / CMS High E	October 2008	XXX	0.54	1.03
Deleted from CPT	Harvard Valued - Utilization over 3(	October 2015			
0.40	Negative IWPUT	February 2018	XXX	0.4	0.30
0.26	Negative IWPUT	February 2018	XXX	0.26	0.19
Deleted from CPT	Negative IWPUT	April 2017			
Deleted from CPT	Negative IWPUT	February 2018			
0.75	Harvard Valued - Utilization over 3(	April 2011	XXX	0.75	2.65
0.80	Codes Reported Together 75% or M	January 2015	XXX	0.8	5.07
0.95	Codes Reported Together 75% or M	October 2015	XXX	0.95	6.37
0.40	MPC List / CMS High Expenditure P	October 2010	XXX	0.4	0.72
CPT Assistant article publ	High Volume Growth1 / High Volun	February 2008	XXX	0.81	2.17
Review action plan. 0.80	CMS High Expenditure Procedural C	September 2017	XXX	0.69	3.11
Review action plan. 0.72	CMS High Expenditure Procedural C	September 2017	XXX	0.61	1.97
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Survey with family	Harvard Valued - Utilization over 3(	October 2020	XXX	0.24	1.45
0.05 and new PE inputs	CMS Fastest Growing, Harvard Valu	October 2008	XXX	0.05	0.60
0.40	Harvard Valued - Utilization over 3(	April 2011	XXX	0.4	0.72
Survey	Harvard Valued - Utilization over 30,000 / CPT Assista		XXX	0.81	4.21
0.18	Harvard Valued - Utilization over 1(	October 2009	XXX	0.18	0.67
Deleted from CPT	CMS Request/Speech Language Pathology Request				
1.30 work RVU and clinic	CMS Request/Speech Language Pat	October 2015	XXX	1.3	0.89
0.43 work RVU and clinic	CMS Request/Speech Language Pathology Request		XXX	0.33	0.35
1.75	CMS Request/Speech Language Pathology Request		XXX	2.24	1.59
1.50	CMS Request/Speech Language Pathology Request		XXX	1.92	1.26
3.36	CMS Request/Speech Language Pathology Request		XXX	3.84	2.75
1.75	CMS Request/Speech Language Pathology Request		XXX	1.92	1.20
Maintain	CMS Request/Speech Language Pat	NA	XXX	1.34	1.09
0.80	CMS-Other - Utilization over 250,0(	October 2014	XXX	0.6	0.60
0.55	CMS-Other - Utilization over 250,0(	October 2014	XXX	0.3	0.34
1.50	Codes Reported Together 95% or More		XXX	1.5	1.66
0.40	Codes Reported Together 95% or M	February 2008	XXX	0.4	0.32
0.48	Codes Reported Together 95% or M	February 2008	XXX	0.48	0.36
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
0.27	Codes Reported Together 95% or M	February 2008	XXX	0.27	0.24
0.25	Codes Reported Together 95% or M	February 2008	XXX	0.25	0.22
Editorial change only	CMS-Other - Utilization over 250,0(	February 2014	XXX	0.29	3.16
Editorial change only	CMS-Other - Utilization over 250,0(	February 2014	ZZZ	0	0.29
0.76	CMS-Other - Utilization over 250,0(	February 2014	XXX	0.67	0.75
0.96	CMS-Other - Utilization over 250,0(	September 2018	XXX	0.87	0.94
0.35	Codes Reported Together 95% or More		XXX	0.35	0.28

0.60 work RVU and clinic	Codes Reported Together 95% or M	February 2008	XXX	0.6	0.48
0.17	CMS Fastest Growing	February 2011	XXX	0.17	0.10
0.20 work RVU and clinic	Codes Reported Together 95% or M	February 2008	XXX	0.2	0.27
0.29 work RVU and clinic	Codes Reported Together 95% or M	February 2008	XXX	0.29	0.14
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
0.55	Codes Reported Together 95% or More		XXX	0.55	0.38
1.00	CMS-Other - Utilization over 30,00(	February 2019	XXX	1	2.43
Deleted from CPT	CMS-Other - Utilization over 30,00(	October 2017	XXX		
Deleted from CPT	CMS-Other - Utilization over 30,00(	February 2019	XXX		
0.45	CMS Fastest Growing	October 2008	XXX	0.35	0.28
0.60	CMS Fastest Growing		XXX	0.55	0.42
1.48 work RVU and clinica	CMS Request/Speech Language Pat	NA	XXX	1.26	0.77
1.75	CMS Request/Speech Language Pathology Request		XXX	1.75	0.85
1.40 work RVU and clinica	CMS Request/Speech Language Pathology Request		XXX	1.4	0.91
1.85 work RVU and clinica	CMS Request/Speech Language Pathology Request		XXX	1.85	1.75
0.70 work RVU and clinica	CMS Request/Speech Language Pathology Request		ZZZ	0.7	0.73
1.50 work RVU and clinica	CMS Request/Speech Language Pathology Request		XXX	1.5	1.51
Maintain	CMS Request/Speech Language Pat	NA	XXX	1.3	1.13
1.34 work RVU and clinica	CMS Request/Speech Language Pat	NA	XXX	1.34	1.26
0.65	CMS Request/Speech Language Pathology Request		ZZZ	0.65	0.26
1.50	CMS Request - Audiology Services	NA	XXX	1.5	1.15
0.35	CMS Request - Audiology Services	NA	ZZZ	0.35	0.30
1.15	CMS Request - Audiology Services	NA	XXX	1.15	0.83
1.40	CMS Request - Audiology Services /	NA	XXX	1.4	1.17
0.33	CMS Request - Audiology Services	NA	ZZZ	0.33	0.28
1.76	CMS Request - Audiology Services	NA	XXX	1.76	1.50
0.25	CMS-Other - Utilization over 30,00(	February 2019	XXX	0.25	0.56
1.00	CMS-Other - Utilization over 30,00(	February 2019	XXX	1	1.57
1.50	CMS-Other - Utilization over 30,00(	February 2019	XXX	1.5	1.84
1.05	CMS-Other - Utilization over 30,00(	February 2019	XXX	1.05	1.41
9.00	MPC List	October 2010	000	9.85	NA
4.00	MPC List	October 2010	ZZZ	0	0.00
11.00	MPC List	October 2010	000	11.74	NA
5.00	MPC List	October 2010	ZZZ	0	0.00
10.49	MPC List	October 2010	000	10.96	NA
4.44	MPC List	October 2010	ZZZ	0	0.00
12.32	MPC List	October 2010	000	12.29	NA
5.50	MPC List	October 2010	ZZZ	0	0.00
10.49	MPC List	October 2010	000	10.95	NA
6.00	MPC List	October 2010	ZZZ	0	0.00
12.32	MPC List	October 2010	000	12.31	NA
12.32	MPC List	October 2010	000	12.31	NA
6.00	MPC List	October 2010	ZZZ	0	0.00
2.25	Harvard Valued - Utilization over 1(	October 2009	000	2	2.49
Remove from screen	High Volume Growth2	April 2013	ZZZ	3.28	NA
Deleted from CPT	MPC List	October 2010			
Deleted from CPT	MPC List	October 2010			

Deleted from CPT	MPC List / Harvard-Valued Annual A	October 2010			
Deleted from CPT	MPC List	October 2010			
Deleted from CPT	CMS Fastest Growing	October 2008	090	22.6	NA
Deleted from CPT	CMS Request - Final Rule for 2019	October 2018	000		
Deleted from CPT	CMS Request - Final Rule for 2019	October 2018	000		
Deleted from CPT	MPC List	October 2010			
Deleted from CPT	MPC List	October 2010			
0.17	CMS High Expenditure Procedural C	September 2011	XXX	0.17	0.24
0.00	High Volume Growth1 / CMS High E	February 2008	XXX	0	0.18
0.17	MPC List / CMS High Expenditure Pr	October 2010	XXX	0.17	0.06
Deleted from CPT	Harvard Valued - Utilization over 1(	October 2009			
Deleted from CPT	Harvard Valued - Utilization over 1(	October 2009			
0.75. CPT Assistant publis	Codes Reported Together 75% or M	February 2010	XXX	0.75	1.26
0.45	Codes Reported Together 75% or M	February 2010	XXX	0.45	0.16
New PE inputs	High Volume Growth1 / CMS Requ	February 2008	XXX	0	0.99
0.30	Codes Reported Together 75% or M	February 2010	XXX	0.3	0.11
New PE Inputs	CMS Request - Practice Expense Re	NA	XXX	0.75	3.15
0.15	Havard Valued - Utilization over 1 M	February 2009	XXX	0.15	0.20
0.00 (PE only)	Havard Valued - Utilization over 1 M	February 2009	XXX	0	0.16
0.15	Havard Valued - Utilization over 1 M	October 2008	XXX	0.15	0.04
0.52	Harvard Valued - Utilization over 1(	October 2009	XXX	0.39	1.89
N/A no physician work	Harvard Valued - Utilization over 1(	October 2009	XXX	0	0.57
N/A no physician work	Harvard Valued - Utilization over 1(	October 2009	XXX	0	1.18
0.52	Harvard Valued - Utilization over 1(	October 2009	XXX	0.39	0.14
0.52	Harvard Valued - Utilization over 1(	October 2009	XXX	0.52	0.19
PE Only	Harvard Valued - Utilization over 1(	October 2009	XXX	0	20.46
Deleted from CPT	CMS Request - 2009 Final Rule, Har	NA			
Deleted from CPT	Harvard Valued - Utilization over 1(	October 2009			
Deleted from CPT	Harvard Valued - Utilization over 1(	October 2009			
Deleted from CPT	CMS Request - 2009 Final Rule, Har	NA			
Deleted from CPT	Harvard Valued - Utilization over 1(	October 2009			
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2008			
Deleted from CPT	Harvard Valued - Utilization over 1(	October 2009			
0.52	Harvard Valued - Utilization over 1(	October 2009	XXX	0.52	5.22
New PE inputs	Harvard Valued - Utilization over 1(	October 2009	XXX	0	0.25
New PE inputs	Harvard Valued - Utilization over 1(	October 2009	XXX	0	4.79
0.52	Harvard Valued - Utilization over 1(	October 2009	XXX	0.52	0.18
0.65	CMS High Expenditure Procedural C	July 2015	XXX	0.65	1.25
0.77	CMS High Expenditure Procedural C	July 2015	XXX	0.77	1.47
0.85	CMS High Expenditure Procedural C	July 2015	XXX	0.85	1.54
0.85	CMS High Expenditure Procedural C	July 2015	XXX	0.85	1.42
1.15	CMS High Expenditure Procedural C	July 2015	XXX	1.15	1.64
1.25	CMS High Expenditure Procedural C	July 2015	XXX	1.25	1.77
0.52	CMS High Expenditure Procedural C	July 2015	XXX	0.52	1.18
0.30	CMS High Expenditure Procedural C	July 2015	XXX	0.3	1.00
0.45	CMS High Expenditure Procedural C	July 2015	XXX	0.45	1.06
0.43	CMS High Expenditure Procedural C	July 2015	XXX	0.43	1.15

0.75	CMS High Expenditure Procedural C	July 2015	XXX	0.75	1.29
0.43	CMS High Expenditure Procedural C	July 2015	XXX	0.43	1.07
0.37	CMS High Expenditure Procedural C	July 2015	XXX	0.37	1.02
0.43	CMS High Expenditure Procedural C	July 2015	XXX	0.43	0.98
0.31	CMS High Expenditure Procedural C	July 2015	XXX	0.31	1.15
0.60	CMS High Expenditure Procedural C	July 2015	XXX	0.6	0.24
0.74	CMS High Expenditure Procedural C	July 2015	XXX	0.74	0.30
New PE inputs and Refer	CMS High Expenditure Procedural C	July 2015	XXX	0	0.73
0.52	CMS High Expenditure Procedural C	July 2015	XXX	0.52	0.21
0.52	CMS High Expenditure Procedural C	July 2015	XXX	0.52	0.21
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
1.46	CMS High Expenditure Procedural C	July 2015	XXX	1.46	4.43
0.92	CMS Request - Practice Expense Re	NA	XXX	0.92	3.23
0.53	CMS Fastest Growing, Harvard Valu	October 2008	XXX	0.53	2.39
0.38	CMS Request - Practice Expense Re	February 2009	ZZZ	0.38	1.16
0.15	CMS-Other - Utilization over 250,0(	October 2013	ZZZ	0.15	0.62
0.07	CMS Request - Practice Expense Re	February 2009	ZZZ	0.07	0.66
1.46; CPT Assistant article	Other - Identified by RUC / Codes R	April 2008	XXX	1.46	4.11
1.75	CMS High Expenditure Procedural C	July 2015	XXX	1.75	5.13
Remove from Modifier -5	Codes Reported Together 95% or More / Modifier -51		000	2.47	23.82
4.32	Codes Reported Together 95% or More		000	4.5	22.80
5.98	Codes Reported Together 95% or More		000	5.99	28.76
4.95	Codes Reported Together 95% or More		000	4.54	22.77
6.15	Codes Reported Together 95% or More		000	5.29	25.34
Remove from Modifier -5	Codes Reported Together 95% or More / Modifier -51		000	5.9	28.29
7.66	Codes Reported Together 95% or More		000	6.64	30.82
6.51	Codes Reported Together 95% or More		000	5.6	25.90
7.34	Codes Reported Together 95% or More		000	6.35	27.63
7.88	Codes Reported Together 95% or More		000	7.1	30.59
9.00	Codes Reported Together 95% or More		000	7.85	33.97
3.73	Codes Reported Together 95% or More		ZZZ	3.73	1.60
2.00	Codes Reported Together 95% or More		ZZZ	2	0.70
1.80	Codes Reported Together 95% or More		ZZZ	1.8	5.08
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
2.00	CMS High Expenditure Procedural C	July 2015	000	2	NA
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			

Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
Deleted from CPT	Codes Reported Together 95% or M	February 2008			
0.77	Negative IWPUT	October 2017	ZZZ	0	NA
0.95	Negative IWPUT	October 2017	ZZZ	0	NA
2.00	Codes Reported Together 95% or More		ZZZ	1.11	0.39
2.10	Codes Reported Together 95% or More		ZZZ	1.13	0.39
1.90	Codes Reported Together 95% or More		ZZZ	0.86	0.30
0.96	Codes Reported Together 95% or More		ZZZ	0.86	3.14
0.97	Codes Reported Together 95% or More		ZZZ	0.97	2.33
0.98	Codes Reported Together 95% or More		ZZZ	0.88	2.81
1.50	High Volume Growth4	October 2016	ZZZ	0	NA
1.00	High Volume Growth4	October 2017	ZZZ	0	NA
5.23	CMS Fastest Growing / High Volum	October 2008	ZZZ	5.23	NA
11.57	Codes Reported Together 75% or M	February 2010	000	0	0.00
1.75	High Volume Growth6	October 2019	ZZZ	0	0.00
Referral to CPT for parent	CMS-Other - Utilization over 30,00(	October 2018	ZZZ	0	0.00
Maintain work RVU and a	Codes Reported Together 75% or M	February 2010	000	0	0.00
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	CMS Fastest Growing/Codes Repor	October 2008			
18.49 (Interim)	Codes Reported Together 75% or M	October 2011	000	14.75	NA
19.75 (Interim)	Codes Reported Together 75% or M	October 2011	000	19.75	NA
6.50 (Interim)	Codes Reported Together 75% or M	October 2011	ZZZ	7.5	NA
20.00 (Interim)	Codes Reported Together 75% or M	October 2011	000	19.77	NA
6.50 (Interim)	Codes Reported Together 75% or M	October 2011	ZZZ	7.5	NA
2.53	High Volume Growth1 / High Volun	February 2008	ZZZ	0	0.00
New PE Inputs	CMS Request - Final Rule for 2018	July 2017	XXX	0	0.40
Remove from screen	Low Value-High Volume	October 2010	XXX	0	0.80
Deleted from CPT	CMS Fastest Growing	October 2008			
Deleted from CPT	CMS Fastest Growing	October 2008			
Deleted from CPT	CMS Fastest Growing	October 2008			
Deleted from CPT	CMS Fastest Growing	October 2008			
Deleted from CPT	CMS Fastest Growing	October 2008			
0.85	High Volume Growth5	October 2018	XXX	0.75	0.59
Reviewe in 2 years. 0.00 F	High Volume Growth3 / Work Neut	September 2016	XXX	0	1.90
Review in 2 years. 0.18	High Volume Growth3 / Work Neu	September 2016	XXX	0.18	0.14
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
0.80	Codes Reported Together 75% or M	February 2010	XXX	0.8	4.97
0.50	CMS High Expenditure Procedural C	January 2012	XXX	0.5	3.23
1.00	Codes Reported Together 75% or M	February 2010	XXX	0.91	7.16
0.70	Codes Reported Together 75% or M	February 2010	XXX	0.5	4.34
Remove from Screen	High Volume Growth6	October 2019	XXX	1	7.28
Remove from Screen	High Volume Growth6	October 2019	XXX	1.15	8.14
Rescind April 2014 recom	New Code in CPT 2015	April 2014	XXX	0	0.00

0.25	CMS Fastest Growing	October 2008	XXX	0.25	2.20
0.45	CMS Fastest Growing	February 2009	XXX	0.45	3.35
0.50	CMS Fastest Growing	February 2009	XXX	0.5	4.23
0.80	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.8	6.56
0.60	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.5	3.82
0.80	CMS Request - Final Rule for 2014	November 2013	XXX	0.8	5.12
0.50	Codes Reported Together 75% or M	February 2010	XXX	0.5	3.21
Deleted from CPT	CMS High Expenditure Procedural (	July 2015			
0.70	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.7	4.97
0.45	Low Value-High Volume / CMS Req	October 2010	XXX	0.45	3.11
1.30	CMS Request - Final Rule for 2014	November 2013	XXX	1.16	6.85
1.00	CMS Fastest Growing / CMS Reque:	October 2008	XXX	0.8	3.95
0.97	CMS-Other - Utilization over 250,0(	April 2013	XXX	0.8	4.61
0.70	CMS-Other - Utilization over 250,0(	October 2013	XXX	0.5	3.00
Deleted from CPT	Codes Reported Together 75%or M	January 2017			
0.80	CMS-Other - Utilization over 30,00(	October 2018	XXX	0.8	6.89
0.50	CMS-Other - Utilization over 30,00(	October 2018	XXX	0.5	3.95
0.60	CMS Fastest Growing / High Volum	October 2008	XXX	0.5	3.90
0.17	Low Value-High Volume	October 2010	XXX	0.17	0.67
Remove from screen - RU	High Volume Growth1	February 2008	XXX	0.52	1.07
Remove from screen - RU	High Volume Growth1	February 2008	XXX	0	0.89
Remove from screen - RU	High Volume Growth1	April 2008	XXX	0.52	0.18
0.22	MPC List / CPT Assistant Analysis 2(	October 2010	XXX	0.22	1.11
0.05	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.05	0.45
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	CMS-Other - Utilization over 20,00(	January 2019	XXX		
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or More-Part2 / CPT A		XXX		
Remove from screen - RU	High Volume Growth1	February 2008	XXX	0.4	1.35
0.70	CMS High Expenditure Procedural (	February 2016	XXX	0.7	1.98
0.48	CMS High Expenditure Procedural (	February 2016	XXX	0.48	0.46
Deleted from CPT	CMS High Expenditure Procedural (	July 2015			
1.42	CMS High Expenditure Procedural (	January 2016	XXX	1.42	3.07
New PE Inputs	Codes Reported Together 75% or More-Part2 /CPT As		XXX	0	0.40
New PE Inputs	CPT Assistant Analysis 2018	April 2019	XXX	0	0.61
New PE Inputs CPT Assist	Codes Reported Together 75% or More-Part2 / CPT A		XXX	0	0.94
New PE Inputs	CPT Assistant Analysis 2018	April 2019	XXX	0	0.65
Remove from screen	High Volume Growth1 / CMS Faste:	February 2008	XXX	0.2	1.27
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
0.31	Codes Reported Together 75% or M	February 2010	XXX	0.26	1.30
0.31	Codes Reported Together 75% or M	February 2010	XXX	0.26	1.00
0.31	Codes Reported Together 75% or M	February 2010	XXX	0.26	0.91
0.19	Codes Reported Together 75% or M	February 2010	ZZZ	0.19	1.52

Deleted from CPT	CMS-Other - Utilization over 20,00(	January 2019	XXX		
New PE inputs	CMS Request - Practice Expense Re	NA	XXX	0	0.06
New PE inputs	CMS Request - Practice Expense Re	NA	XXX	0	0.10
New PE inputs	CMS Fastest Growing, CMS Request	October 2008	XXX	0	0.78
Deleted from CPT	High Volume Growth1 / Codes Rep(	February 2008	XXX		
0.01	Low Value-Billed in Multiple Units /	October 2010	XXX	0.01	0.10
Deleted from CPT	Low Value-Billed in Multiple Units	October 2010			
New PE Inputs	High Volume Growth5	October 2018	XXX	0	0.57
Deleted from CPT	Low Value-Billed in Multiple Units	October 2010			
0.07	Low Value-Billed in Multiple Units	October 2010	XXX	0.07	0.17
0.14	Low Value-Billed in Multiple Units	October 2010	XXX	0.14	0.47
New PE Inputs.	Low Value-Billed in Multiple Units /	October 2010	XXX	0.01	0.23
0.01	Low Value-Billed in Multiple Units	October 2010	XXX	0.01	0.12
New PE Inputs	CMS High Expenditure Procedural (	January 2012	XXX	0	0.26
New PE Inputs	CMS High Expenditure Procedural (	September 2011	XXX	0	0.32
0.06	Low Value-Billed in Multiple Units /	October 2010	XXX	0.06	0.41
0.06	Low Value-Billed in Multiple Units	October 2010	XXX	0.06	2.59
0.06	MPC List / CMS High Expenditure P(	October 2010	XXX	0.06	0.39
PE Only. Referral to CPT A	High Volume Growth2		XXX	0	1.64
Re-review at RAW. New I	High Volume Growth2 / Work Neut	October 2013	XXX	0	4.47
Re-review at RAW. 0.70.	High Volume Growth / Work Neutra	April 2013	XXX	0.7	0.28
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
PE Only	High Volume Growth4	May 2018	XXX	0	0.00
2.00	High Volume Growth4	May 2018	XXX	2	0.82
2.50	High Volume Growth4	May 2018	XXX	2.5	1.25
3.00	High Volume Growth4	May 2018	XXX	3	1.37
3.86	High Volume Growth4	May 2018	XXX	3.86	1.91
3.86	High Volume Growth4	May 2018	XXX	3.86	1.95
4.70	High Volume Growth4	May 2018	XXX	4.7	2.36
4.75	High Volume Growth4	May 2018	XXX	4.75	2.45
6.00	High Volume Growth4	May 2018	XXX	6	3.02
5.40	High Volume Growth4	May 2018	XXX	5.4	2.82
7.58	High Volume Growth4	May 2018	XXX	7.58	3.83
1.05	CMS Fastest Growing	October 2009	XXX	0.85	3.98
1.00	CMS Fastest Growing	October 2009	XXX	0.85	1.72
0.90 and New PE inputs	CMS Request - Practice Expense Re	NA	XXX	0.9	3.55

1.20	CMS Fastest Growing	October 2009	XXX	1.2	10.97
1.28	CMS Fastest Growing	October 2009	XXX	0.93	1.95
1.25	CMS Fastest Growing	October 2009	XXX	1.28	10.24
1.74	CMS Fastest Growing	October 2009	XXX	1.74	17.45
2.50	CMS Fastest Growing / MPC List	February 2010	XXX	2.5	15.30
2.60	CMS Fastest Growing	October 2009	XXX	2.6	15.99
1.08	CMS Request - Final Rule for 2016	July 2015	XXX	1.08	8.96
1.63	CMS Request - Final Rule for 2016	July 2015	XXX	1.63	10.70
1.08	CMS High Expenditure Procedural C	January 2012	XXX	1.08	9.91
1.08	CMS High Expenditure Procedural C	September 2011	XXX	1.08	12.12
1.08	CMS High Expenditure Procedural C	January 2012	XXX	1.08	10.95
Deleted from CPT	High Volume Growth4	May 2018			
Deleted from CPT	High Volume Growth3 / CMS-Other	October 2015			
Deleted from CPT	High Volume Growth3 / CMS-Other	October 2017			
Deleted from CPT	High Volume Growth3 / CMS-Other	October 2017			
Deleted from CPT	High Volume Growth3 / CMS-Other	October 2017			
0.96	Harvard Valued - Utilization over 1C	October 2009	XXX	0.96	2.48
1.54	Codes Reported Together 75% or M	February 2010	XXX	1.54	3.43
1.87	Codes Reported Together 75% or M	February 2010	XXX	1.87	4.63
1.99	Codes Reported Together 75% or M	February 2010	XXX	1.99	5.25
0.79	Codes Reported Together 75% or More-Part1		XXX	0.79	2.45
1.18	Codes Reported Together 75% or More-Part1		XXX	1.18	3.05
0.37	Codes Reported Together 75% or M	October 2011	XXX	0.37	2.60
0.37	Codes Reported Together 75% or M	October 2011	XXX	0.37	2.28
0.35	Codes Reported Together 75% or M	February 2010	ZZZ	0.35	1.59
0.92	Codes Reported Together 75% or M	February 2010	ZZZ	0.86	2.09
0.73	Codes Reported Together 75% or M	February 2010	ZZZ	0.71	1.84
Deleted from CPT	MPC List / Codes Reported Togethe	October 2010			
Deleted from CPT	CMS High Expenditure Procedural C	September 2011			
Deleted from CPT	Codes Reported Together 75% or M	February 2010			
1.00	Codes Reported Together 75% or More-Part1		XXX	1	1.73
1.37	Codes Reported Together 75% or More-Part1		XXX	1.25	2.20
1.77	Codes Reported Together 75% or More-Part1		XXX	1.5	2.63
2.80	Codes Reported Together 75% or More-Part1		XXX	2	3.41
3.34	Codes Reported Together 75% or More-Part1		XXX	2.5	4.00
4.00	Codes Reported Together 75% or More-Part1		XXX	3	4.50
4.20	Codes Reported Together 75% or More-Part1		XXX	3.56	5.15
Refer to CPT Assistant. 0.!	Different Performing Specialty from	October 2009	XXX	0.9	1.66
Refer to CPT Assistant. 0.!	High Volume Growth1 / CMS Faste!	February 2008	XXX	0.96	2.08
Refer to CPT Assistant. 0.!	Codes Reported Together 75% or M	October 2019	XXX	0.9	2.88
Refer to CPT Assistant. 1.'	Codes Reported Together 75% or More-Part1		XXX	1.73	2.58
0.54 and New PE Inputs	Codes Reported Together 75% or M	February 2010	XXX	0.54	4.02
0.54 and New PE Inputs	Codes Reported Together 75% or M	February 2010	XXX	0.54	3.68
1.50	Codes Reported Together 75% or M	February 2010	XXX	1.5	5.39
1.50	Codes Reported Together 75% or M	February 2010	XXX	1.5	5.60
0.35	High Volume Growth3	October 2015	XXX	0.35	1.60
Deleted from CPT	Codes Reported Together 75% or More-Part1				

Deleted from CPT	Codes Reported Together 75% or More-Part1				
0.86 and new PE inputs	Codes Reported Together 75% or M	January 2013	XXX	0.86	9.64
2.25 and new PE inputs	Codes Reported Together 75% or M	January 2013	XXX	2.25	13.62
0.60	Codes Reported Together 75% or M	January 2012	XXX	0.6	NA
2.00	Codes Reported Together 75% or M	January 2012	XXX	0	0.00
Deleted from CPT	Codes Reported Together 75% or M	January 2018	XXX	0	0.00
Deleted from CPT	CMS Fastest Growing	February 2009			
Deleted from CPT	High Volume Growth4	October 2016			
Deleted from CPT	CMS Fastest Growing	February 2009			
Remove from screen	High Volume Growth1	February 2008	XXX	2.45	8.95
Deleted from CPT	CMS Fastest Growing	October 2008			
1.98	CMS High Expenditure Procedural C	July 2015	XXX	1.98	5.29
0.45	Harvard Valued - Utilization over 1(	February 2010	XXX	0.35	0.17
0.78	Harvard Valued - Utilization over 1(	October 2009	XXX	0.78	0.59
0.80	Harvard Valued - Utilization over 1(	February 2010	XXX	0.8	0.76
Deleted from CPT	Harvard Valued - Utilization over 1(	February 2010			
Deleted from CPT	CMS Request - Final Rule for 2016	July 2015			
Deleted from CPT	CMS Request - Final Rule for 2016	July 2015			
0.95 and Refer to CPT Ass	High Volume Growth2 / CMS Reque	June 2017	XXX	0.73	0.38
1.19 and Refer to CPT Ass	High Volume Growth2 / CMS Reque	June 2017	XXX	0.97	0.50
Deleted from CPT	CMS Request - Final Rule for 2016	July 2015			
Deleted from CPT	CMS Request - Final Rule for 2016	July 2015			
Not part of family	CMS Request - Final Rule for 2016	July 2015	XXX	0.8	NA
Not part of family	CMS Request - Final Rule for 2016	July 2015	XXX	0.3	0.73
Not part of family	CMS Request - Final Rule for 2016	July 2015	XXX	0.65	0.93
1.25 and Refer to CPT Ass	High Volume Growth2 / CMS Reque	June 2017	XXX	0.91	0.48
1.00 and Refer to CPT Ass	High Volume Growth2 / CMS Reque	June 2017	ZZZ	0.8	0.41
0.00	Different Performing Specialty from	April 2010	XXX	0	2.68
0.77	High Volume Growth1 / Codes Rep	February 2008	XXX	0.77	2.50
Remove from Modifier -5	Modifier -51 Exempt	January 2018	XXX	0.75	0.49
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	High Volume Growth2 / Different P	April 2013			
1.75	CMS Request/Speech Language Pat	January 2016	XXX	1.75	1.06
New PE Inputs	CMS High Expenditure Procedural C	January 2017	XXX	0	0.28
Deleted from CPT	CMS High Expenditure Procedural C	January 2017			
2.50	CMS High Expenditure Procedural C	June 2017	XXX	2.56	1.07
1.10	CMS High Expenditure Procedural C	June 2017	ZZZ	1.16	0.47
1.86	CMS High Expenditure Procedural C	July 2015	XXX	1.86	0.83
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	CMS High Expenditure Procedural C	July 2015			
Deleted from CPT	High Volume Growth2 / CMS High E	April 2013			
1.71	CMS High Expenditure Procedural C	June 2017	ZZZ	1.71	0.56
1.70	CMS High Expenditure Procedural C	January 2016	XXX	1.7	1.28
New PE Inputs	CMS High Expenditure Procedural C	January 2016	XXX	0	0.13
2.50	CMS High Expenditure Procedural C	June 2017	XXX	2.56	0.79
1.90	CMS High Expenditure Procedural C	June 2017	ZZZ	1.96	0.57

2.50	CMS High Expenditure Procedural C	June 2017	XXX	2.56	1.16
1.90	CMS High Expenditure Procedural C	June 2017	ZZZ	1.96	0.96
0.55	CMS High Expenditure Procedural C	June 2017	XXX	0.55	0.75
0.46	CMS High Expenditure Procedural C	June 2017	ZZZ	0.46	0.72
New PE Inputs	CMS High Expenditure Procedural C	June 2017	XXX	0	1.06
New PE Inputs	CMS High Expenditure Procedural C	June 2017	ZZZ	0	1.06
New PE Inputs	CMS High Expenditure Procedural C	June 2017	XXX	0	0.05
Deleted from CPT	Negative IWPUT	September 2018			
Deleted from CPT	Negative IWPUT	September 2018			
Deleted from CPT	Negative IWPUT	September 2018			
Deleted from CPT	Negative IWPUT	September 2018			
Deleted from CPT	Negative IWPUT	April 2017			
Deleted from CPT	Negative IWPUT	September 2018			
2.10	Negative IWPUT	September 2018	XXX	2.1	0.60
1.45	Negative IWPUT	September 2018	XXX	1.45	0.41
0.50	Negative IWPUT	September 2018	ZZZ	0.5	0.14
0.21	Negative IWPUT	September 2018	XXX	0.21	0.06
0.10	Negative IWPUT	September 2018	ZZZ	0.1	0.03
1.55	Negative IWPUT	September 2018	XXX	1.55	0.44
0.55	Negative IWPUT	September 2018	ZZZ	0.55	0.16
1.50	Negative IWPUT	September 2018	XXX	1.5	0.71
0.54	Negative IWPUT	September 2018	ZZZ	0.54	0.26
0.17	CMS High Expenditure Procedural C	July 2015	XXX	0.17	0.85
0.09	CMS High Expenditure Procedural C	July 2015	ZZZ	0.09	0.30
0.21	CMS High Expenditure Procedural C	September 2011	XXX	0.21	1.86
0.18	CMS High Expenditure Procedural C	April 2013	ZZZ	0.18	0.45
0.19	CMS High Expenditure Procedural C	September 2011	ZZZ	0.19	0.71
0.17	CMS High Expenditure Procedural C	April 2013	ZZZ	0.17	0.43
0.17	Different Performing Specialty from	April 2013	XXX	0.17	0.23
0.18	CMS High Expenditure Procedural C	July 2015	XXX	0.18	1.00
0.10	CMS High Expenditure Procedural C	July 2015	ZZZ	0.1	0.38
0.17	should be on N/R LOI just added to	January 2016	XXX	0.17	0.40
0.21	CMS High Expenditure Procedural C	July 2015	XXX	0.21	2.10
0.19	CMS High Expenditure Procedural C	July 2015	XXX	0.19	0.74
New PE inputs	CMS Request - Practice Expense Re	NA	000	0.52	1.95
New PE inputs	CMS Request - Practice Expense Re	NA	000	0.8	3.05
0.24	CMS High Expenditure Procedural C	July 2015	XXX	0.24	2.95
0.20	CMS High Expenditure Procedural C	July 2015	ZZZ	0.2	1.54
0.28 and new PE inputs	Codes Reported Together 75% or M	February 2010	XXX	0.28	3.88
0.19 and new PE inputs	CMS High Expenditure Procedural C	January 2012	ZZZ	0.19	0.69
New PE inputs	Codes Reported Together 75% or M	February 2010	XXX	0.21	3.92
0.21 and new PE inputs	CMS High Expenditure Procedural C	January 2012	ZZZ	0.21	1.81
New PE inputs	CMS Request - Practice Expense Re	NA	000	2.12	25.94
0.00 PE Only	High Volume Growth1 / CMS Faste	February 2008	XXX	0	4.24
0.48	CMS High Expenditure Procedural C	January 2017	000	0.48	6.40
1.01	CMS High Expenditure Procedural C	January 2017	000	1.01	7.44
PE Only	CMS High Expenditure Procedural C	July 2015	XXX	0	3.48

1.15. Review in two years	CMS Fastest Growing / CPT Assistar	October 2008	000	1.15	3.56
1.30. Review in two years	High Volume Growth1 / CMS Faste:	February 2008	000	1.3	3.85
2.10. Review in two years	High Volume Growth1 / CMS Faste:	October 2008	000	2.1	4.86
Deleted from CPT	CMS High Expenditure Procedural C	September 2011			
Deleted from CPT	CMS High Expenditure Procedural C	February 2015			
Deleted from CPT	CMS High Expenditure Procedural C	February 2015			
Deleted from CPT	CMS High Expenditure Procedural C	February 2015			
No specialty society inter	Physical Medicine and Rehabilitatio	April 2016	XXX	0.06	0.11
0.25	Physical Medicine and Rehabilitatio	April 2016	XXX	0.25	0.17
0.18	Physical Medicine and Rehabilitatio	April 2016	XXX	0.18	0.20
0.18	Codes Reported Together 75% or M	February 2010	XXX	0.18	0.16
0.06	Codes Reported Together 75% or M	February 2010	XXX	0.06	0.10
0.17	Physical Medicine and Rehabilitatio	April 2016	XXX	0.17	0.34
0.25	CMS High Expenditure Procedural C	July 2015	XXX	0.25	0.17
0.26	Physical Medicine and Rehabilitatio	April 2016	XXX	0.26	0.32
0.21	Physical Medicine and Rehabilitatio	April 2016	XXX	0.21	0.21
0.21	Low Value-High Volume / CMS High	October 2010	XXX	0.21	0.20
0.45	Codes Reported Together 75% or M	February 2010	XXX	0.45	0.40
0.50	CMS High Expenditure Procedural C	September 2011	XXX	0.5	0.49
0.48	CMS High Expenditure Procedural C	July 2015	XXX	0.48	0.60
0.45	Codes Reported Together 75% or M	February 2010	XXX	0.45	0.40
1.50	High Volume Growth3	January 2017			
0.43	CMS High Expenditure Procedural C	September 2011	XXX	0.43	0.35
0.29	CMS-Other - Utilization over 500,0(	April 2011	XXX	0.29	0.22
0.75	CMS High Expenditure Procedural C	February 2015	XXX	1.54	1.33
1.18	CMS High Expenditure Procedural C	February 2015	XXX	1.54	1.33
1.50	CMS High Expenditure Procedural C	February 2015	XXX	1.54	1.33
0.75	CMS High Expenditure Procedural C	February 2015	XXX	0.96	1.00
0.88	CMS High Expenditure Procedural C	February 2015	XXX	1.54	1.24
1.20	CMS High Expenditure Procedural C	February 2015	XXX	1.54	1.24
1.70	CMS High Expenditure Procedural C	February 2015	XXX	1.54	1.24
0.80	CMS High Expenditure Procedural C	February 2015	XXX	0.96	0.91
0.44	CMS High Expenditure Procedural C	September 2011	XXX	0.44	0.67
Deleted from CPT	High Volume Growth2 / High Volun	April 2013			
0.48	Physical Medicine and Rehabilitatio	April 2016	XXX	0.48	1.24
0.45	Codes Reported Together 75% or M	October 2012	XXX	0.45	0.50
0.48	Physical Medicine and Rehabilitatio	April 2016	XXX	0.48	0.43
0.48	High Volume Growth2	April 2013	XXX	0.48	0.44
0.88	Site of Service Anomaly / High Volu	September 2007	000	0.77	2.12
0.50	Site of Service Anomaly / High Volu	September 2007	ZZZ	0.5	0.79
Maintain	Physical Medicine and Rehabilitatio	April 2016	XXX	0	0.00
0.55	High Volume Growth2	April 2013	XXX	0.55	0.67
0.60	High Volume Growth2	April 2013	XXX	0.6	0.85
0.11	High Volume Growth2	May 2013	XXX	0.41	9.58
0.46	High Volume Growth2	May 2013	XXX	0.46	9.26
Maintain	Physical Medicine and Rehabilitatio	April 2016	XXX	0.4	11.52
Remove from screen	High Volume Growth1	February 2008	XXX	0.62	0.47

0.50	Physical Medicine and Rehabilitatio	April 2016	XXX	0.5	0.92
0.50	Physical Medicine and Rehabilitatio	April 2016	XXX	0.5	0.70
Deleted from CPT	Physical Medicine and Rehabilitatio	April 2016			
0.48	Physical Medicine and Rehabilitatio	April 2016	XXX	0.48	1.08
0.53	CMS Request - Medical Nutrition Th	NA	XXX	0.53	0.53
0.45	CMS Request - Medical Nutrition Th	NA	XXX	0.45	0.46
0.50	Harvard Valued - Utilization over 1(	February 2010	000	0.46	0.42
0.75	Harvard Valued - Utilization over 1(	October 2009	000	0.71	0.55
1.00	Harvard Valued - Utilization over 1(	October 2009	000	0.96	0.69
1.25	Harvard Valued - Utilization over 1(	February 2010	000	1.21	0.81
1.50	Harvard Valued - Utilization over 1(	February 2010	000	1.46	0.94
0.46	CMS High Expenditure Procedural C	September 2011	000	0.46	0.34
0.71	CMS High Expenditure Procedural C	September 2011	000	0.71	0.44
0.96	CMS High Expenditure Procedural C	September 2011	000	0.96	0.54
0.46	CMS High Expenditure Procedural C	September 2011	XXX	0.46	0.29
Deleted from CPT	Moderate Sedation Review	January 2014			
Deleted from CPT	Moderate Sedation Review	January 2014			
Deleted from CPT	Moderate Sedation Review	January 2014			
Deleted from CPT	Moderate Sedation Review	January 2014			
Deleted from CPT	Moderate Sedation Review	January 2014			
0.50	Moderate Sedation Review	January 2014	XXX	0.5	1.99
0.25	Moderate Sedation Review	January 2014	XXX	0.25	1.24
1.90	Moderate Sedation Review	January 2014	XXX	1.9	NA
1.84	Moderate Sedation Review	January 2014	XXX	1.65	NA
PE Only	CMS Request - Practice Expense Re	NA	XXX	0	0.15
PE Only	CMS Request - Practice Expense Re	May 2014	XXX	0	0.12
2.11	CMS-Other - Utilization over 250,0(	April 2013	XXX	2.11	0.78
0.48	CMS Request - Final Rule for 2018	June 2017	XXX	0.48	NA
0.93	CMS Request - Final Rule for 2018	June 2017	XXX	0.93	NA
1.42	CMS Request - Final Rule for 2018	June 2017	XXX	1.6	NA
2.60	CMS Request - Final Rule for 2018	June 2017	XXX	2.74	NA
3.80	CMS Request - Final Rule for 2018	June 2017	XXX	4	NA
Refer to CPT	CMS Request - Final Rule for 2020	November 2019	XXX	2.1	0.95
Refer to CPT	CMS Request - Final Rule for 2020	November 2019	ZZZ	1	0.47
Deleted from CPT	High Volume Growth3	September 2016			
Deleted from CPT	High Volume Growth3	September 2016			
RUC recommended to su	CMS-Other - Utilization over 250,0(	April 2016	XXX	1.73	1.13
RUC recommended to su	CMS-Other - Utilization over 250,0(	April 2016	XXX	1.73	1.13
1.45. Refer to CPT Assista	New and Revised Service (Not part	NA	XXX	1.45	0.82
CMS investigate and revie	Work Neutrality 2018	October 2019	XXX	1.88	2.41
CMS investigate and revie	Work Neutrality 2018	October 2019	XXX	2.05	2.24
CMS investigate and revie	Work Neutrality 2018	October 2019	ZZZ	0.82	0.82
Review in 2 years	RUC Referral to CPT Assistant	January 2014	XXX	1.5	0.86
Review in 2 years	RUC Referral to CPT Assistant	January 2014	ZZZ	1.4	0.64
Remove from screen	Low Value-High Volume / CMS-Oth	October 2010	XXX	0.45	0.63
Remove from screen	High Volume Growth4	October 2016	XXX	0.18	0.47
0.84	MPC List	January 2014	000	0.84	4.65

3.36	MPC List	September 2011	000	3.26	6.56
0.90	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.9	0.66
0.25	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.25	0.19
3.36	MPC List	September 2011	000	3.26	6.56
0.42	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.26	0.36
Remove from screen	CMS-Other - Utilization over 500,0(	April 2011	000	0.17	0.52
0.42	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.26	0.36
0.00 (PE Only)	CMS-Other - Utilization over 100,0(	April 2016	XXX	0	3.35
0.45	CMS 000-Day Global Typically Repo	July 2016	000	0.31	3.20
RUC recommended to su	CMS Fastest Growing / CMS-Other	October 2008	XXX	0.45	0.70
RUC recommended to su	CMS Fastest Growing / CMS-Other	October 2008	XXX	0.67	0.81
Recommend deletion aft	CMS Fastest Growing / CMS-Other	October 2008	XXX	1.73	1.21
Recommend deletion aft	CMS-Other - Utilization over 250,0(	April 2016	XXX	1.73	1.25
Assume CMS will delete	CMS Fastest Growing / CMS-Other	February 2008			
Assume CMS will delete	CMS Fastest Growing / CMS-Other	February 2008			
Assume CMS will delete	CMS Fastest Growing / CMS-Other	February 2008			
Remove from screen - RU	CMS Fastest Growing	February 2008	XXX	0	0.27
Remove from screen - RU	CMS Fastest Growing	February 2008	XXX	0	0.28
Created Category I code,	High Volume Growth3	January 2016	XXX	0	1.87
Created Category I code,	CMS Fastest Growing / High Volum	February 2008	XXX	0	1.69
Created Category I code,	CMS Fastest Growing / High Volum	February 2008	XXX	0.18	0.04
0.61	CMS Fastest Growing / CMS 000-Da	October 2008	000	0.61	0.79
Maintain/Remove from s	CMS Fastest Growing	February 2008	XXX	0.45	0.46
Recommend CMS delete	CMS-Other - Utilization over 30,00(	October 2017	ZZZ	0.6	0.95
0.18	Low Value-High Volume / CMS-Oth	October 2010	XXX	0.18	0.19
Submit action plan	CMS-Other - Utilization over 20,00(	January 2019	XXX	0.52	0.27
Recommend CMS delete.	CMS-Other - Utilization over 30,00(	October 2018	XXX		
Deleted from CPT	CMS-Other - Utilization over 30,00(	October 2017			
Deleted from CPT	CMS-Other - Utilization over 30,00(	October 2017			
CPT Assistant article publ	Final Rule for 2015 / High Volume (	July 2014			
Refer to CPT	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.65	0.34
CMS delete	High Volume Growth5	October 2018	XXX	0	0.00
RUC recommended to su	CMS-Other - Utilization over 100,0(	April 2016	XXX	2.6	2.11
RUC recommended to su	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.17	0.24
Review action plan	CMS-Other - Utilization over 20,00(	October 2020	XXX	1.39	NA
Review action plan	CMS-Other - Utilization over 20,00(	October 2020	XXX	2	NA
4.00	Final Rule for 2015	July 2014	XXX	3.6	6.46
Maintain	CMS-Other - Utilization over 20,00(	October 2020	XXX	1.7	1.43
Maintain	CMS-Other - Utilization over 20,00(	October 2020	XXX	1.7	1.43
Deleted from CPT	CMS-Other - Utilization over 100,0(	April 2016			
RUC recommended to su	CMS-Other - Utilization over 250,0(	April 2013	XXX	2.6	2.10
RUC recommended to su	CMS-Other - Utilization over 250,0(	April 2013	XXX	1.92	1.78
RUC recommended to su	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.18	0.35
RUC recommended to su	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.18	0.35
Survey, but no specialty i	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.45	0.28
RUC recommended to su	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.45	0.28
0.93	CMS-Other - Utilization over 30,00(	October 2018	XXX	0.93	0.44

Remove from screen	CMS-Other - Utilization over 100,0(	April 2016	XXX	0.6	NA
RUC recommended to sui	CMS Request - Final Rule for 2013	November 2012			
RUC recommended to sui	CMS Request - Final Rule for 2013	November 2012			
Maintain	CMS-Other - Utilization over 20,00(	October 2020	XXX	0.1	1.57
Review action plan	CMS-Other - Utilization over 20,00(	October 2020	ZZZ	0.87	0.85
Refer to CPT	CMS-Other - Utilization over 20,00(	October 2020	XXX	0.58	3.88
Remove from screen	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.39	1.80
Review action plan	CMS-Other - Utilization over 20,00(	October 2020	XXX	0	7.57
Review action plan	CMS-Other - Utilization over 20,00(	October 2020	XXX	0	7.59
Remove from screen	CMS-Other - Utilization over 20,00(	January 2019	XXX	0	7.57
Review action plan	CMS-Other - Utilization over 20,00(	October 2020	XXX	0	11.01
Review action plan	CMS-Other - Utilization over 20,00(	October 2020	YYY	0	0.00
No recommendation on p	CMS Request - Final Rule for 2020	November 2019			
0.42	CMS-Other - Utilization over 30,00(	October 2017	XXX	0.26	0.36
RUC recommended to sui	CMS-Other - Utilization over 30,00(	October 2018	XXX	0.37	0.85

2021 Fac PE RVU	2021 PLI RVU	2019e Medicare Utilization	Referred to CPT Asst	CPT Asst Status	CPT Asst Complete	Referred to CPT	Refer to CPT Background	CPT Meeting
0.00	0.00	30,245	FALSE			FALSE		
0.00	0.00	89,969	FALSE			FALSE		
0.00	0.00	58,933	FALSE			FALSE		
0.00	0.00	########	FALSE			FALSE	In Septembe	September 2016
0.00	0.00	105,226	FALSE			FALSE	In Septembe	September 2016
			FALSE			TRUE	In April 2016,	September 2016
			FALSE			TRUE	In April 2016,	September 2016
0.00	0.00	########	FALSE			FALSE	In Septembe	September 2016
0.00	0.00	517,650	FALSE			FALSE	In Septembe	September 2016
0.00	0.00	492,977	FALSE			FALSE	In Septembe	September 2016
0.00	0.00		FALSE			FALSE		
0.00	0.00	58,939	FALSE			FALSE		
0.00	0.00	57,829	FALSE			TRUE	At the April 2	October 2020
0.00	0.00	17,980	FALSE			FALSE		
0.00	0.00		FALSE			FALSE		October 2020
0.00	0.00	311,884	FALSE			TRUE	This service v	October 2020
			FALSE			FALSE		October 2020
			FALSE			FALSE		October 2020
			FALSE			FALSE		October 2020
			FALSE			FALSE		October 2020
			FALSE			FALSE		October 2020
			FALSE			FALSE		October 2020
0.00	0.00	2,656	FALSE			FALSE		
0.00	0.00	16,708	FALSE			TRUE	At the April 2	October 2020
0.00	0.00	49,050	FALSE			FALSE		
0.00	0.00	28,857	FALSE			FALSE		
0.44	0.09		FALSE			TRUE	In the CY 202	February 2021
0.52	0.11		FALSE			TRUE	In the CY 202	February 2021
0.74	0.15		FALSE			TRUE	In the CY 202	February 2021
0.00	0.00	5,679	FALSE			FALSE		
0.00	0.00	12	FALSE			FALSE		
NA	0.02		FALSE			FALSE		
			FALSE			FALSE	At the April 2	October 2020
0.34	0.11	503	FALSE			FALSE		
0.50	0.15	145,323	FALSE			FALSE		
0.37	0.10	33,658	FALSE			FALSE		
0.67	0.19	395	FALSE			FALSE		
0.41	0.11	32	FALSE			FALSE		
0.78	0.21	5,300	FALSE			FALSE		
0.56	0.15	99	FALSE			FALSE		
0.00	0.00	69	FALSE			FALSE		
0.00	0.00	21	FALSE			FALSE		
0.44	0.14	17,957	FALSE			TRUE	The specialty	June 2017
			FALSE			TRUE	The specialty	June 2017

0.94	0.26	8,525	FALSE	FALSE	Deleted nine	October 2012
0.52	0.09	41,492	FALSE	FALSE		
1.66	0.13	368,976	FALSE	FALSE		
2.57	0.31	134,001	FALSE	FALSE		
1.68	0.14	43,240	FALSE	FALSE		
2.44	0.48	9,692	FALSE	FALSE		
			FALSE	TRUE	Descriptor er	October 2009
			FALSE	TRUE	Descriptor er	October 2009
0.62	0.13	########	FALSE	TRUE	Descriptor er	October 2009
1.40	0.42	456,527	FALSE	TRUE	Descriptor er	October 2009
1.83	0.64	88,567	FALSE	TRUE	Descriptor er	October 2009
0.18	0.09	492,140	FALSE	FALSE		
0.40	0.20	239,254	FALSE	FALSE		
0.71	0.34	66,673	FALSE	FALSE		
0.08	0.04	886,591	FALSE	FALSE		
0.11	0.04	########	FALSE	FALSE		
0.14	0.05	346,586	FALSE	FALSE		
			FALSE	TRUE	Prior to the J	February 2017
			FALSE	TRUE	Prior to the J	February 2017
0.38	0.05	########	FALSE	FALSE		February 2017
0.22	0.04	########	FALSE	FALSE		February 2017
0.46	0.09	388,339	FALSE	FALSE		February 2017
0.25	0.05	97,094	FALSE	FALSE		February 2017
0.56	0.11	37,327	FALSE	FALSE		February 2017
0.31	0.05	7,020	FALSE	FALSE		February 2017
0.33	0.05	104,786	FALSE	FALSE		
0.50	0.09	205,570	FALSE	FALSE		
0.59	0.11	114,770	FALSE	FALSE		
0.69	0.13	16,712	FALSE	FALSE		
0.24	0.06	100,773	FALSE	FALSE		
0.39	0.09	102,882	FALSE	FALSE		
0.54	0.11	51,111	FALSE	FALSE		
0.51	0.13	14,010	FALSE	FALSE		
0.44	0.09	74,188	FALSE	FALSE		
0.61	0.13	100,460	FALSE	FALSE		
0.73	0.14	46,378	FALSE	FALSE		
0.94	0.17	8,180	FALSE	FALSE		
0.04	0.01	837,707	FALSE	FALSE		
0.07	0.04	########	FALSE	FALSE		
0.12	0.04	########	FALSE	FALSE		
0.43	0.09	378,522	FALSE	FALSE		
1.25	0.13	201,719	FALSE	FALSE		
			FALSE	TRUE	The Americar	October 2015
0.43	0.10	62,237	FALSE	FALSE		
0.30	0.05	265,694	FALSE	FALSE		
0.46	0.09	73,970	FALSE	FALSE		
0.39	0.14	33,888	FALSE	TRUE	In January 20	May 2018

0.52	0.21	13,060	FALSE		TRUE	In January 20 May 2018
0.61	0.25	4,500	FALSE		TRUE	In January 20 May 2018
0.81	0.32	2,345	FALSE		FALSE	
0.31	0.15	184,284	FALSE		FALSE	
0.37	0.21	142,967	FALSE		FALSE	
0.44	0.26	22,345	FALSE		FALSE	
0.46	0.38	6,059	FALSE		FALSE	
0.59	0.45	1,137	FALSE		FALSE	
0.81	0.58	357	FALSE		FALSE	
0.35	0.21	90,553	FALSE		FALSE	
0.26	0.23	50,435	FALSE		FALSE	
0.33	0.30	6,842	FALSE		FALSE	
0.42	0.38	3,321	FALSE		FALSE	
0.59	0.51	526	FALSE		FALSE	
0.67	0.64	72	FALSE		FALSE	
0.74	0.74	17	FALSE		FALSE	
2.15	0.25	63,049	FALSE		FALSE	
2.71	0.26	280,457	FALSE		FALSE	
2.60	0.41	25,707	FALSE		FALSE	
2.92	0.64	4,889	FALSE		FALSE	
3.22	0.84	1,073	FALSE		FALSE	
3.61	1.02	458	FALSE		FALSE	
1.86	0.26	20,831	FALSE		FALSE	
2.58	0.31	52,449	FALSE		FALSE	
2.57	0.45	2,304	FALSE		FALSE	
3.48	0.64	337	FALSE		FALSE	
3.99	1.04	89	FALSE		FALSE	
4.23	1.21	50	FALSE		FALSE	
2.29	0.28	54,376	FALSE		FALSE	
2.58	0.34	75,683	FALSE		FALSE	
2.66	0.43	9,218	FALSE		FALSE	
2.32	0.54	2,576	FALSE		FALSE	
3.43	0.79	281	FALSE		FALSE	
5.03	0.94	41	FALSE		FALSE	
5.28	1.07	25	FALSE		FALSE	
2.49	0.36	6,433	FALSE		FALSE	
3.38	0.39	102,897	FALSE		FALSE	
0.68	0.19	26,791	FALSE		FALSE	
3.22	0.37	12,693	TRUE	1st article: complete	FALSE	September 2018
3.08	0.43	207,941	TRUE	1st article: complete	FALSE	September 2018
0.78	0.20	31,342	TRUE	1st article: complete	FALSE	September 2018
2.90	0.43	41,454	FALSE		FALSE	
3.52	0.49	309,273	FALSE		FALSE	
1.22	0.26	17,262	FALSE		FALSE	
			FALSE		TRUE	Specialties ar October 2012
3.26	0.51	33,842	FALSE		FALSE	
3.83	0.61	54,926	FALSE		FALSE	

1.28	0.34	938	FALSE	FALSE		
7.16	1.03	7,303	FALSE	FALSE		
8.68	1.49	9,637	FALSE	FALSE		
8.16	0.97	17,817	FALSE	FALSE		
9.54	1.25	19,350	FALSE	FALSE		
8.42	1.03	67,406	FALSE	FALSE		
9.98	1.25	45,011	FALSE	FALSE		
8.93	1.04	90,113	FALSE	FALSE		
10.86	1.34	31,224	FALSE	FALSE		
			FALSE	TRUE	The specialty	February 2009
10.74	1.90	38,864	FALSE	FALSE		February 2009
1.96	0.64	40,086	FALSE	FALSE		February 2009
2.17	0.64	24,066	FALSE	FALSE		
2.44	0.64	32,464	FALSE	FALSE		
9.16	1.88	13,549	FALSE	FALSE		
8.42	1.59	9,650	FALSE	FALSE		
			FALSE	FALSE		
			FALSE	FALSE		
			FALSE	TRUE	The specialty	October 2010
			FALSE	FALSE		
8.53	1.10	9,947	FALSE	FALSE		
11.30	1.35	13,328	FALSE	FALSE		
0.73	0.22	111,779	FALSE	FALSE		February 2011
0.12	0.05	14,569	FALSE	FALSE		February 2011
1.67	0.64	5,775	FALSE	FALSE		February 2011
0.36	0.16	25,402	FALSE	FALSE		February 2011
0.72	0.19	122,551	FALSE	FALSE		February 2011
0.17	0.06	6,340	FALSE	FALSE		February 2011
1.89	0.70	1,720	FALSE	FALSE		February 2011
0.46	0.20	2,936	FALSE	FALSE		February 2011
			FALSE	TRUE	The specialty	October 2010
			FALSE	FALSE		
			FALSE	FALSE		
			FALSE	FALSE		
			FALSE	TRUE	The specialty	October 2010
			FALSE	FALSE		February 2011
			FALSE	FALSE		February 2011
			FALSE	FALSE		February 2011
			FALSE	TRUE	The specialty	October 2010
			FALSE	FALSE		February 2011
			FALSE	FALSE		
			FALSE	FALSE		
			FALSE	TRUE	The specialty	October 2010
			FALSE	FALSE		February 2011
9.36	1.85	292	FALSE	FALSE		
9.64	1.69	691	FALSE	FALSE		
9.34	1.45	1,483	FALSE	FALSE		

8.61	1.13	4,346	FALSE			FALSE		
11.48	1.67	1,767	FALSE			FALSE		
12.59	2.11	2,362	FALSE			TRUE	In April 2016	September 2016
			FALSE			TRUE	The specialty	September 2016
12.20	2.36	5,657	FALSE			FALSE		
16.46	4.72	24,232	FALSE			FALSE		September 2016
15.54	3.20	1,501	FALSE			FALSE		September 2016
15.12	3.52	6,218	FALSE			FALSE		September 2016
10.87	1.67	2,046	FALSE			TRUE	CPT code 157	February 2009 & F
6.24	1.15		FALSE			FALSE		
6.08	1.15		FALSE			FALSE		
1.15	0.43		FALSE			FALSE		
6.12	1.15		FALSE			FALSE		
1.11	0.41		FALSE			FALSE		
1.97	0.68	8,429	FALSE			FALSE		February 2011
8.60	0.59	97,994	FALSE			FALSE		
0.77	0.13	15,272	FALSE			FALSE		
1.22	0.26	1,908	FALSE			FALSE		
1.38	0.37	879	TRUE	Oct 2012	Yes	FALSE		
0.90	0.05	########	FALSE			FALSE		
0.02	0.00	########	FALSE			FALSE		
1.34	0.13	874,685	FALSE			FALSE		
3.87	0.39	3,933	FALSE			FALSE		
5.00	0.56	1,449	FALSE			FALSE		
6.78	0.92	5,081	FALSE			FALSE		
1.15	0.06	########	FALSE			FALSE		
1.29	0.09	122,909	FALSE			FALSE		
0.50	0.06	234,080	TRUE	Sep 2016	Yes	TRUE	In January 20	September 2016
1.17	0.13	140,325	FALSE			FALSE		
1.40	0.15	287,333	FALSE			FALSE		
1.35	0.15	53,690	FALSE			FALSE		
1.51	0.17	82,281	FALSE			FALSE		
1.48	0.16	86,818	FALSE			FALSE		
1.66	0.21	81,831	FALSE			FALSE		
3.57	0.59	829,586	FALSE			FALSE		
1.89	0.31	509,267	FALSE			FALSE		
3.20	0.52	140,796	FALSE			FALSE		
1.76	0.28	57,990	FALSE			FALSE		
0.50	0.09	19,946	FALSE			FALSE		
4.50	0.86	1,614	FALSE			FALSE		
1.19	0.32	60,561	FALSE			FALSE		October 2012
0.60	0.16	4,476	FALSE			FALSE		October 2012
1.12	0.32	118,588	FALSE			FALSE		October 2012
0.56	0.15	15,269	FALSE			FALSE		October 2012
1.32	0.30	5,634	FALSE			FALSE		October 2012
0.66	0.15	1,195	FALSE			FALSE		October 2012
			FALSE			FALSE		October 2012

			FALSE	FALSE		October 2012
0.72	0.16	30,514	FALSE	FALSE		October 2012
0.36	0.09	3,292	FALSE	FALSE		October 2012
0.72	0.20	3,526	FALSE	FALSE		October 2012
0.36	0.13	338	FALSE	FALSE		October 2012
0.62	0.15	25,714	FALSE	FALSE		October 2012
0.31	0.09	2,002	FALSE	FALSE		October 2012
0.92	0.21	266	FALSE	FALSE		October 2012
0.46	0.11	60	FALSE	FALSE		October 2012
			FALSE	FALSE		October 2012
			FALSE	FALSE		October 2012
			FALSE	FALSE		October 2012
9.73	3.60	24,587	FALSE	FALSE		
12.69	4.33	6,042	FALSE	FALSE		
13.22	2.89	7,501	FALSE	FALSE		
9.81	1.94	7,433	FALSE	FALSE		
16.67	2.69	6,479	FALSE	TRUE	Originally ref	October 2009
			FALSE	TRUE	This service v	June 2009
			FALSE	TRUE	A RUC memb	February 2018
0.75	0.15	12,355	FALSE	FALSE		
1.11	0.22	14,341	FALSE	FALSE		
1.25	0.31	6,533	FALSE	FALSE		
3.17	1.02	4,354	FALSE	TRUE	In April 2015,	October 2015
3.09	0.63	1,693	FALSE	FALSE		
0.57	0.16	102,673	FALSE	FALSE		
0.30	0.09	848,059	FALSE	FALSE		
0.31	0.09	163,234	FALSE	FALSE		
0.36	0.09	350,677	FALSE	FALSE		
0.41	0.09	378,100	FALSE	FALSE		
0.30	0.09	444,325	FALSE	TRUE	Ultrasound a	October 2013
0.36	0.10	46,354	FALSE	FALSE		October 2013
0.32	0.09	466,622	FALSE	TRUE	Ultrasound a	October 2013
0.42	0.13	56,334	FALSE	FALSE		October 2013
0.42	0.13	########	FALSE	TRUE	Ultrasound a	October 2013
0.51	0.15	########	FALSE	FALSE		October 2013
0.41	0.10	28,400	FALSE	FALSE		
5.36	1.02	55,761	FALSE	FALSE		
13.87	2.76	3,150	FALSE	FALSE		
4.95	0.75	6,209	FALSE	FALSE		
0.68	0.26		FALSE	FALSE		
0.51	0.21		FALSE	FALSE		
1.14	0.45		FALSE	FALSE		
0.82	0.32		FALSE	FALSE		
1.19	0.47		FALSE	FALSE		
0.98	0.39		FALSE	FALSE		
1.85	0.51	4,436	FALSE	FALSE		
2.76	0.85	4,599	FALSE	FALSE		

		14,815	TRUE	Deleted fo	N/A	TRUE	In October 2(	May 2018
9.04	1.66	506	FALSE			TRUE	CPT develope	June 2008
8.55	0.95	3,614	FALSE			FALSE		
			FALSE			FALSE		
10.39	2.91	490	FALSE			TRUE	CPT develope	June 2008
			FALSE			TRUE	Refer to CPT	February 2014
			FALSE			TRUE	Referred to C	October 2014
			FALSE			FALSE		October 2013
4.31	2.36	357	FALSE			FALSE		October 2013
5.32	2.82	468	FALSE			FALSE		October 2013
7.08	4.32	62	FALSE			FALSE		October 2013
2.69	0.26	190	TRUE	Jan 2018	yes	FALSE		October 2013
6.59	1.74	737	FALSE			FALSE		October 2013
11.11	3.42	235	FALSE			TRUE	CPT develope	June 2008
17.74	5.74	6,695	FALSE			FALSE		
			FALSE			TRUE	In October 2(	May 2016
4.53	0.74	6,942	FALSE			FALSE		
3.71	0.97	3,686	FALSE			FALSE	Joint Workgr	February 2014
3.58	0.92	4,104	FALSE			FALSE		February 2014
1.42	0.61	2,505	FALSE			FALSE		February 2014
4.81	1.53	24,396	FALSE			FALSE		February 2014
4.57	1.44	26,776	FALSE			FALSE		February 2014
1.68	0.74	15,688	FALSE			FALSE		February 2014
			FALSE			TRUE	Joint Workgr	February 2014
			FALSE			TRUE	Joint Workgr	February 2014
			FALSE			FALSE		February 2014
			FALSE			FALSE		February 2014
			FALSE			FALSE		February 2014
			FALSE			FALSE		February 2014
18.10	5.96	908	TRUE	Oct 2009	Yes	FALSE		
17.59	7.64	40,145	FALSE			FALSE		October 2009
3.20	1.94	35,696	FALSE			FALSE		October 2009
14.17	5.27	4,675	FALSE			TRUE	Referred to t	October 2009
15.54	6.05	20,376	FALSE			TRUE	In January 20	September 2016
2.57	1.50	17,132	FALSE			FALSE		October 2009
16.98	6.31	44,894	FALSE			TRUE	The Workgro	October 2010
3.19	1.88	144,296	FALSE			FALSE		
17.38	7.12	5,654	FALSE			TRUE	The Workgro	October 2010
2.56	1.63	1,875	FALSE			FALSE		
18.89	7.96	38,096	FALSE			TRUE		October 2010
4.04	2.37	14,338	FALSE			TRUE		October 2010
6.67	3.87	8,692	FALSE			FALSE		
14.05	5.38	4,231	FALSE			TRUE	The Workgro	June 2010
			FALSE			TRUE	While prepar	October 2015
2.72	1.59	1,934	FALSE			FALSE		
11.54	4.02	2,131	FALSE			FALSE		
1.96	1.25	532	FALSE			FALSE		

6.48	1.89	628	FALSE			TRUE	CPT develope	June 2008
7.02	1.57	677	FALSE			TRUE	CPT develope	June 2008
8.52	1.46	6,767	FALSE			FALSE		
8.95	1.55	1,826	FALSE			FALSE		
0.37	0.09	35,070	FALSE			FALSE		
8.24	1.53	2,277	FALSE			FALSE		
10.61	2.22	3,333	FALSE			FALSE		
10.91	2.32	12,002	FALSE			FALSE		
9.58	1.82	408	FALSE			FALSE		
12.52	2.68	2,359	FALSE			FALSE		
9.89	1.93	19,997	FALSE			FALSE		
9.61	2.10	1,487	FALSE			FALSE		
16.29	4.25	67,382	FALSE			FALSE		
4.11	0.46	339	TRUE	Jan 2018	yes	FALSE		
5.76	0.59	32,747	FALSE			FALSE		
5.50	0.79	173	TRUE	Jan 2018	yes	FALSE		
4.47	0.70	14,692	TRUE	Jan 2018	yes	FALSE		
6.41	0.93	2,327	TRUE	Jan 2018	yes	FALSE		
6.24	0.92	556	TRUE	Jan 2018	yes	FALSE		
6.96	1.07	890	TRUE	Jan 2018	yes	FALSE		
4.78	0.86	1,283	TRUE	Jan 2018	yes	FALSE		
7.43	1.10	382	TRUE	Jan 2018	yes	FALSE		
8.89	1.37	1,034	FALSE			FALSE		
7.35	1.10	3,150	FALSE			FALSE		
9.21	1.46	919	FALSE			FALSE		
8.02	1.35	1,402	FALSE			FALSE		
8.81	1.46	7,690	FALSE			FALSE		
6.78	1.15	667	TRUE	Jan 2018	yes	FALSE		
7.68	1.24	20,527	TRUE	Jan 2018	yes	FALSE		
9.77	1.62	2,015	FALSE			FALSE		
10.43	1.82	9,419	FALSE			FALSE		
11.23	2.10	7,290	FALSE			FALSE		
13.92	2.68	18,114	FALSE			FALSE		
6.10	0.96	445	TRUE	Jan 2018	yes	FALSE		
8.34	1.25	2,453	FALSE			FALSE		
4.93	0.58	105,433	FALSE			FALSE		
6.50	0.79	1,997	TRUE	Sep 2012	Yes	FALSE		
5.13	0.64	18,598	FALSE			FALSE		
12.28	1.73	1,150	FALSE			FALSE		
13.25	2.21	66	FALSE			FALSE		
14.08	2.53	42	FALSE			FALSE		
15.38	1.24	10,824	FALSE			FALSE		
4.61	0.74	471	TRUE	Jan 2018	yes	FALSE		
3.43	0.34	6,976	TRUE	Jan 2018	yes	FALSE		
4.32	0.63	522	TRUE	Jan 2018	yes	FALSE		
3.93	0.61	5,900	TRUE	Jan 2018	yes	FALSE		
7.31	1.91	339	FALSE			TRUE	CPT develope	June 2008

6.60	1.13	1,884	FALSE			FALSE		
0.81	0.14	489,612	FALSE			TRUE	Refer to CPT	February 2011
14.40	3.90	169,584	FALSE			FALSE		
19.86	6.01	10,863	FALSE			FALSE		
			FALSE			TRUE	Refer to CPT	October 2015
			FALSE			FALSE		
2.07	0.30	11,080	FALSE			FALSE		
3.74	0.86	206	FALSE			FALSE		
5.61	1.10	3,070	FALSE			FALSE		
7.17	1.15	1,509	TRUE	Jan 2018	yes	FALSE		
7.83	2.32	194	TRUE	Jan 2018	yes	FALSE		
14.10	3.47	57,280	FALSE			FALSE		
11.78	2.74	260	TRUE	Jan 2018	yes	FALSE		
14.43	3.60	5,947	FALSE			FALSE		
14.41	3.58	83,430	FALSE			FALSE		
0.73	0.75	3,180	FALSE			FALSE		
9.11	2.21	762	TRUE	Jan 2018	yes	FALSE		
5.75	1.03	8,333	TRUE	Jan 2018	yes	FALSE		
7.98	1.53	5,456	TRUE	Jan 2018	yes	FALSE		
10.28	3.04	3,753	FALSE			FALSE		
5.87	1.14	814	FALSE			FALSE		
0.30	0.10	60,267	FALSE			TRUE	In June 2017,	February 2018
			TRUE	Clinical Exa	Yes	TRUE	In October 20	June 2017
13.11	3.44	15,803	FALSE			FALSE		
14.37	3.88	312,130	FALSE			FALSE		
8.76	2.22	385	TRUE	Jan 2018	yes	FALSE		
8.41	1.92	386	TRUE	Jan 2018	yes	FALSE		
7.25	1.19	531	TRUE	Jan 2018	yes	FALSE		
8.95	1.62	269	TRUE	Jan 2018	yes	FALSE		
11.22	3.20	211	FALSE			TRUE	CPT develope	June 2008
5.54	1.10	552	FALSE			TRUE	CPT develope	June 2008
10.13	2.15	1,673	FALSE			TRUE	CPT Editorial	June 2008
7.91	1.59	905	FALSE			TRUE	CPT Editorial	June 2008
8.78	1.44	2,516	FALSE			FALSE		
8.89	1.51	3,117	FALSE			FALSE		
6.05	0.90	4,084	FALSE			FALSE		
6.02	0.93	7,093	FALSE			FALSE		
8.39	1.35	1,376	FALSE			FALSE		
9.72	1.73	4,579	FALSE			FALSE		
7.06	1.25	1,229	TRUE	Jan 2018	yes	FALSE		
6.33	1.03	369	TRUE	Jan 2018	yes	FALSE		
8.74	1.59	7,279	FALSE			FALSE		
6.25	1.03	2,962	TRUE	Jan 2018	yes	FALSE		
10.01	1.98	10,858	FALSE			FALSE		
6.15	1.10	3,490	TRUE	Jan 2018	yes	FALSE		
6.59	1.28	659	TRUE	Jan 2018	yes	FALSE		
5.53	0.93	2,234	TRUE	Jan 2018	yes	FALSE		

1.87	0.25	3,770	FALSE			FALSE		
3.34	0.54	6,661	FALSE			FALSE		
6.33	1.02	5,470	FALSE			FALSE		
3.71	0.56	1,069	FALSE			FALSE		
6.30	0.96	5,154	FALSE			FALSE		
5.30	0.71	14,469	FALSE			FALSE		
4.25	0.45	11,425	FALSE			FALSE		
4.95	0.56	71,537	FALSE			FALSE		
5.72	0.75	4,662	FALSE			FALSE		October 2015
			FALSE			FALSE		October 2015
5.60	0.78	4,067	FALSE			FALSE		October 2015
5.88	0.71	6,950	FALSE			FALSE		October 2015
			FALSE			TRUE	In January 20	October 2015
			FALSE			FALSE		October 2015
8.29	1.30	586	FALSE			FALSE		October 2015
5.94	0.74	9,559	FALSE			FALSE		October 2015
7.24	1.10	2,793	FALSE			FALSE		October 2015
6.00	0.86	2,903	FALSE			FALSE		October 2015
6.82	0.99	4,743	FALSE			FALSE		October 2015
7.88	1.51	2,519	FALSE			FALSE		
4.37	0.62	1,640	FALSE			FALSE		
3.72	0.28	29,629	FALSE			FALSE		
1.21	0.22	689	TRUE	Jan 2018	yes	FALSE		
9.84	1.81	4,389	FALSE			FALSE		
9.25	1.63	3,581	FALSE			FALSE		
7.58	1.25	3,996	FALSE			FALSE		
1.34	0.44	30,702	FALSE			FALSE		
1.30	0.42	15,013	FALSE			FALSE		
0.90	0.15	68,396	FALSE			FALSE		
0.29	0.15	25,626	FALSE			FALSE		
0.13	0.02	13,693	FALSE			FALSE		
			TRUE	Deleted fr	Yes	TRUE	The specialty	October 2008
0.13	0.02	16,307	FALSE			FALSE		
0.14	0.04	5,004	FALSE			FALSE		
0.14	0.04	3,404	FALSE			FALSE		
0.94	0.21	36,431	FALSE			FALSE		
0.13	0.02	13,018	FALSE			FALSE		
0.12	0.02	27,045	FALSE			FALSE		
0.09	0.04	213,060	FALSE			FALSE		
0.06	0.02	56,200	FALSE			FALSE		
0.16	0.06	265,752	FALSE			FALSE		
0.18	0.02	194,064	FALSE			FALSE		
			TRUE	Aug 2016	Yes	FALSE		September 2016
			TRUE	Aug 2016	Yes	FALSE		September 2016
0.10	0.01	2,715	TRUE	Aug 2016	Yes	FALSE		
			FALSE			TRUE	This service v	February 2012
6.74	1.16	698	FALSE			FALSE		

7.61	1.39	9,153	FALSE			TRUE	In October 2(	September 2019
8.03	1.52	45,349	FALSE			TRUE	In October 2(	September 2019
9.29	1.73	39,895	FALSE			FALSE		
1.52	0.59	78,655	FALSE			FALSE		
12.97	2.98	69,465	FALSE			FALSE		
11.38	2.53	18,992	FALSE			FALSE		
6.50	1.00	136	FALSE			FALSE		
6.66	1.02	125	FALSE			FALSE		
5.85	0.97	1,031	FALSE			FALSE		
11.84	2.70	1,173	FALSE			FALSE		
7.79	1.17	4	FALSE			FALSE		
1.75	0.43	49,954	FALSE			FALSE		
16.15	1.73	4,626	FALSE			FALSE		
0.37	0.17	88,372	FALSE			FALSE		
0.47	0.26	48,496	FALSE			FALSE		
0.78	0.34	5,245	FALSE			FALSE		
1.14	0.36	800	FALSE			FALSE		
0.61	0.15	660,545	FALSE			FALSE		
1.65	0.36	137,754	FALSE			FALSE		
1.71	0.38	29,505	FALSE			FALSE		
7.80	0.93	1,366	FALSE			FALSE		
1.62	0.36	6,458	FALSE			FALSE		
3.78	1.10	470	FALSE			FALSE		September 2016
4.26	1.25	8,502	FALSE			FALSE		September 2016
2.19	0.59	13,255	FALSE			FALSE		September 2016
2.84	0.78	11,287	FALSE			TRUE	In April 2015,	September 2016
1.68	0.43	15,592	FALSE			FALSE		September 2016
3.83	1.10	5,920	FALSE			FALSE		September 2016
4.04	1.17	7,903	FALSE			FALSE		September 2016
2.36	0.64	28,703	FALSE			FALSE		September 2016
3.27	0.93	15,859	FALSE			TRUE	In April 2015,	September 2016
1.84	0.48	3,280	FALSE			TRUE	In April 2015,	September 2016
2.11	0.58	4,121	FALSE			TRUE	In April 2015,	September 2016
1.50	0.37	28,533	FALSE			FALSE		
1.67	0.43	8,725	FALSE			TRUE	In April 2015,	September 2016
1.38	0.34	2,120	FALSE			TRUE	In April 2015,	September 2016
2.28	0.63	19,499	FALSE			FALSE		September 2016
0.72	0.43	263,123	TRUE	Oct 2016	yes	FALSE		
20.58	2.95	2	FALSE			FALSE		October 2015
20.16	2.81	12	FALSE			FALSE		October 2015
24.58	3.03		FALSE			FALSE		October 2015
24.60	3.03	23	FALSE			FALSE		October 2015
2.32	0.59	5,271	FALSE			FALSE		
0.87	0.13	658,434	FALSE			FALSE		
1.31	0.25	86,928	FALSE			FALSE		
21.35	1.99	21	FALSE			TRUE	CPT code 315	October 2015
			FALSE			TRUE	CPT code 315	October 2015

21.83	2.42	15	FALSE	TRUE	CPT code 315	October 2015
17.87	2.10	15	FALSE	TRUE	CPT code 315	October 2015
			FALSE	TRUE	CPT code 315	October 2015
16.65	1.88	1,148	FALSE	FALSE		October 2015
22.15	3.43	23	FALSE	FALSE		October 2015
2.38	1.03	23,498	FALSE	FALSE		
3.93	1.10	4	FALSE	FALSE		
2.34	1.03	801	FALSE	FALSE		
2.02	1.26	278	FALSE	FALSE		
14.66	1.76	1,593	FALSE	FALSE		
9.01	0.82	761	FALSE	FALSE		
			FALSE	TRUE	In January 20	October 2014
1.03	0.27	52,315	FALSE	FALSE	In January 20	October 2014
1.01	0.21	26,278	FALSE	FALSE		
1.04	0.22	118,565	FALSE	FALSE		
1.17	0.26	19,149	FALSE	FALSE	In January 20	October 2014
1.42	0.43	2,173	FALSE	FALSE	In January 20	October 2014
1.30	0.26	32,291	FALSE	FALSE	In January 20	October 2014
1.36	0.31	13,745	FALSE	FALSE	In January 20	October 2014
0.32	0.09	3,890	FALSE	FALSE		
0.42	0.11	1,196	FALSE	FALSE		
1.13	0.26	35,233	FALSE	FALSE		May 2016
1.09	0.25	4,580	FALSE	FALSE		May 2016
1.59	0.42	25,507	FALSE	FALSE	In January 20	October 2014
1.74	0.45	13,988	FALSE	FALSE	In January 20	October 2014
0.44	0.11	8,214	FALSE	FALSE	In January 20	October 2014
			FALSE	FALSE	Deleted nine	October 2012
		70,068	FALSE	TRUE	In October 2(	February 2019
1.00	0.26		FALSE	FALSE		
			FALSE	TRUE	In Septembe	February 2012
			FALSE	TRUE	In Septembe	February 2012
			FALSE	TRUE	In Septembe	February 2012
12.36	6.28	247	FALSE	FALSE		
11.53	5.93	4,630	FALSE	FALSE		
12.58	6.33	294	FALSE	FALSE		
12.02	5.79	15	FALSE	FALSE		
1.01	0.52	33,044	FALSE	TRUE	In Septembe	February 2012
0.60	0.19	13,649	FALSE	FALSE	4 new thorac	February 2012
0.75	0.20	229,865	FALSE	FALSE	4 new thorac	February 2012
0.80	0.30	3,833	FALSE	FALSE	4 new thorac	February 2012
0.98	0.26	38,244	FALSE	FALSE	4 new thorac	February 2012
10.61	5.67	9,229	FALSE	FALSE		
		6,698	FALSE	FALSE		September 2018
		87	FALSE	FALSE		September 2018
		1,147	FALSE	TRUE	A RUC memb	September 2018
1.55	0.94		FALSE	FALSE		September 2018
1.60	0.92		FALSE	FALSE		September 2018

1.72	0.99		FALSE			FALSE		September 2018
1.49	0.82		FALSE			FALSE		September 2018
6.59	3.29	122	FALSE			TRUE	In April 2018,	May 2018
6.29	3.02	4,535	FALSE			TRUE	In April 2018,	May 2018
4.56	1.74	11,733	FALSE			TRUE	33213 - This (	February 2011
4.88	1.91	103,628	FALSE			TRUE	33213 - This (	February 2011
3.37	1.12	317	FALSE			TRUE	33213 - This (	February 2011
3.43	1.18	1,113	FALSE			TRUE	33213 - This (	February 2011
3.87	1.24	268	FALSE			FALSE		February 2011
3.56	1.17	3,452	FALSE			FALSE		February 2011
3.68	1.25	24,395	FALSE			FALSE		February 2011
3.96	1.30	5,526	FALSE			FALSE		February 2011
3.86	1.37	140	FALSE			FALSE		February 2011
4.04	1.43	121	FALSE			FALSE		February 2011
3.01	0.71	8,743	FALSE			TRUE	33213 - This (	February 2011
3.64	1.31	217	FALSE			TRUE	33213 - This (	February 2011
2.61	0.69	6,043	FALSE			TRUE	33213 - This (	February 2011
8.73	3.34	42,661	FALSE			TRUE	33213 - This (	February 2011
3.90	1.30	3,000	FALSE			FALSE		February 2011
4.01	1.36	7,980	FALSE			FALSE		February 2011
4.17	1.44	11,831	FALSE			FALSE		February 2011
			FALSE			FALSE		February 2017
			FALSE			FALSE		February 2017
15.58	9.42	17,344	FALSE			FALSE		
19.29	11.59	7,658	FALSE			FALSE		
13.23	7.71	60,180	FALSE			FALSE		
11.30	6.87	56	TRUE	July 2016	Yes	FALSE		
7.30	3.73		TRUE	July 2016	Yes	FALSE		
21.49	14.69	1	TRUE	July 2016	Yes	FALSE		
4.98	3.12		FALSE			FALSE		September 2019
7.24	3.96		FALSE			FALSE		September 2019
2.88	1.45		FALSE			FALSE		September 2019
19.72	13.40	1,812	FALSE			FALSE		
31.88	20.34	667	FALSE			FALSE		February 2014
1.82	1.21	603	FALSE			FALSE		February 2014
2.00	1.41	1,395	FALSE			FALSE		February 2014
1.49	0.75	4,436	FALSE			FALSE		February 2014
1.41	0.74	5,342	FALSE			FALSE		February 2014
2.36	1.84	1	FALSE			FALSE		February 2014
2.56	1.76	1,439	FALSE			FALSE		February 2014
2.63	2.07		FALSE			FALSE		February 2014
2.74	2.04	354	FALSE			FALSE		February 2014
4.73	3.63	352	FALSE			FALSE		February 2014
1.08	0.78		FALSE			FALSE		February 2014
1.08	0.78	72	FALSE			FALSE		February 2014
1.35	1.02		FALSE			FALSE		February 2014
			FALSE			TRUE	October 201	February 2014

			FALSE	TRUE	October 201	February 2014
1.35	1.02	20	FALSE	FALSE		February 2014
2.60	2.04		FALSE	FALSE		February 2014
2.74	2.14	22	FALSE	FALSE		February 2014
1.08	0.78		FALSE	FALSE		February 2014
1.44	0.97	383	FALSE	FALSE		February 2014
1.56	1.18		FALSE	FALSE		February 2014
1.58	1.25	543	FALSE	FALSE		February 2014
2.85	2.24	1	FALSE	FALSE		February 2014
2.99	2.28	221	FALSE	FALSE		February 2014
1.13	0.93	41	FALSE	FALSE		February 2014
4.28	3.41	40	FALSE	FALSE		February 2014
2.74	2.14	14	FALSE	FALSE		February 2014
6.98	5.46	824	FALSE	FALSE		
9.51	8.40	99	FALSE	FALSE		
7.34	6.16	1,118	FALSE	FALSE		
11.18	10.63	141	FALSE	FALSE		
8.07	6.86	13,089	FALSE	FALSE		
11.45	10.52	641	FALSE	FALSE		
6.55	5.13	652	FALSE	FALSE		
8.89	8.52	85	FALSE	FALSE		
1.40	1.51	3,632	FALSE	FALSE		
4.80	3.43	1,186	FALSE	FALSE		
1.26	1.42	367	FALSE	FALSE		
4.47	2.71	1,214	FALSE	FALSE		
0.53	0.59	16,159	FALSE	FALSE		
1.40	1.21	487	FALSE	FALSE		
1.32	1.43	206	FALSE	FALSE		
2.00	1.63	798	FALSE	FALSE		
			FALSE	FALSE		
			FALSE	TRUE	Referred to C	September 2016
			FALSE	FALSE		
			FALSE	FALSE		
			FALSE	FALSE		
			FALSE	FALSE		
0.90	0.98	9,013	FALSE	TRUE	Referred to C	September 2016
1.44	1.67	82	FALSE	FALSE		
			FALSE	TRUE	Referred to C	September 2016
			FALSE	FALSE		
1.29	1.96	46	FALSE	FALSE		
0.48	0.64	366	FALSE	FALSE		
			FALSE	FALSE		
6.69	5.13	35,904	FALSE	FALSE		
			FALSE	FALSE		
			FALSE	FALSE		
			FALSE	FALSE		February 2010
			FALSE	FALSE		February 2010

			FALSE	FALSE		
			FALSE	FALSE		February 2010
			FALSE	FALSE		
			FALSE	TRUE	The code is p	February 2010
			FALSE	TRUE	In January 20	October 2015
			FALSE	TRUE	The code is p	Removed from CPT
			FALSE	TRUE	The code is p	February 2010
			FALSE	TRUE	The code is p	February 2010
			FALSE	TRUE	In January 20	October 2015
			FALSE	TRUE	In January 20	October 2015
			FALSE	TRUE	The RUC recc	February 2010
			FALSE	TRUE	The RUC recc	February 2010
			FALSE	TRUE	The RUC recc	February 2010
			FALSE	TRUE	The RUC recc	February 2010
			FALSE	TRUE	The RUC recc	February 2010
			FALSE	TRUE	The RUC recc	February 2010
4.08	1.25	823	FALSE	TRUE	The RUC iden	September 2018
3.38	1.55		FALSE	FALSE		September 2018
3.00	1.74		FALSE	FALSE		September 2018
		484	FALSE	TRUE	The RUC iden	September 2018
		199	FALSE	TRUE	The RUC iden	September 2018
		1,616	FALSE	TRUE	The RUC iden	September 2018
0.07	0.01		FALSE	TRUE	The specialty societies indicated	
0.62	0.39	14,377	FALSE	FALSE	The Workgro	February 2011
0.49	0.36	20,331	FALSE	FALSE		
			FALSE	TRUE	Referred to t	February 2009
			FALSE	FALSE		October 2008
			FALSE	FALSE		October 2008
1.44	0.54	45,269	FALSE	TRUE	The Workgroup recommends the	
1.66	0.95	4,580	FALSE	TRUE	The Workgroup recommends the	
1.98	1.25	4,059	FALSE	TRUE	In September 2011, the specialty	
0.30	0.15	1,711	FALSE	FALSE		
1.08	0.84	2,095	FALSE	TRUE	The Workgro	February 2012
1.77	1.21	7,752	FALSE	TRUE	The Workgro	February 2012
2.20	1.39	29,312	FALSE	TRUE	The Workgro	February 2012
2.68	1.62	36,594	FALSE	TRUE	The Workgro	February 2012
2.13	1.41	11,267	FALSE	TRUE	The Workgro	February 2012
2.61	1.58	32,221	FALSE	TRUE	The Workgro	February 2012
0.83	0.52	13,979	FALSE	TRUE	The Workgro	February 2012
1.71	1.12	2,336	FALSE	TRUE	The Workgro	February 2012
1.43	0.76	40,259	FALSE	TRUE	An extensive	February 2010 and
1.35	0.99	36,476	FALSE	FALSE		
1.65	1.03	66,061	FALSE	FALSE		
0.28	0.13	26,334	FALSE	TRUE	The code is p	February 2010
1.51	0.86	3,603	FALSE	FALSE		
2.26	1.45	8,044	FALSE	FALSE		
2.15	0.81	1,646	FALSE	FALSE		

2.47	1.59	162	FALSE			FALSE		
0.07	0.02	155,240	FALSE			FALSE		
1.73	1.10	109,583	FALSE			FALSE		
0.72	0.54	7,170	FALSE			FALSE		
1.76	1.02	61,677	FALSE			FALSE		
0.78	0.52	6,461	FALSE			FALSE		
2.06	0.68	697	FALSE			FALSE		
1.06	0.14	235	TRUE	May 2018	yes	FALSE		September 2016
1.00	0.13	2,896	TRUE	May 2018	yes	FALSE		September 2016
0.94	0.22	192	TRUE	May 2018	yes	FALSE		September 2016
0.79	0.15	28,894	TRUE	May 2018	yes	FALSE		September 2016
			TRUE	May 2018	yes	FALSE		September 2016
0.65	0.26	1,069	TRUE	Sep 2009	Yes	TRUE	CPT code 365	September 2016
0.97	0.13	8,303	TRUE	May 2018	yes	FALSE		September 2016
0.37	0.15	26	FALSE			FALSE		
0.50	0.21	409,595	FALSE			FALSE		
0.34	0.21	3	FALSE			TRUE	In October 2(	September 2017
0.61	0.21	14,961	FALSE			TRUE	In October 2(	September 2017
0.65	0.17	25	FALSE			FALSE		
0.56	0.19	88,728	FALSE			FALSE		
0.41	0.13	4,270	FALSE			TRUE	In October 2(	September 2017
0.20	0.09	581,132	FALSE			FALSE		
4.81	2.95	5,179	FALSE			FALSE		
4.87	3.18	7,456	FALSE			FALSE		
4.90	3.08	1,343	FALSE			FALSE		
4.61	2.84	30,775	FALSE			FALSE		
			FALSE			TRUE	Added as par	February 2014
5.66	3.41	1,949	FALSE			FALSE		
4.56	2.87	20,101	FALSE			FALSE		
			FALSE			TRUE	The RUC refe	February 2009
			FALSE			TRUE	The RUC revi	October 2015
1.05	0.48	68,183	FALSE			FALSE		October 2015
1.47	0.66	199,617	FALSE			FALSE		October 2015
1.82	0.96	20,847	FALSE			FALSE		October 2015
2.16	1.03	4,595	FALSE			FALSE		October 2015
2.73	1.16	41,205	FALSE			FALSE		October 2015
3.02	1.41	14,028	FALSE			FALSE		October 2015
0.83	0.43	67,888	FALSE			FALSE		October 2015
1.13	0.64	5,376	FALSE			FALSE		October 2015
1.11	0.63	5,424	FALSE			FALSE		October 2015
2.36	0.69	893	FALSE			FALSE		
1.38	0.61	25,555	FALSE			FALSE		February 2011
1.20	1.72	32	FALSE			FALSE		February 2011
2.01	0.96	7,478	FALSE			FALSE		February 2011
			FALSE			TRUE	The Workgro	October 2011
			FALSE			TRUE		June 2011
			FALSE			TRUE	In February 2	February 2013

			FALSE	TRUE	In February 2	February 2013
			FALSE	TRUE	In February 2	February 2013
			FALSE	TRUE	In February 2	February 2013
			FALSE	TRUE	In February 2	February 2013
			FALSE	TRUE	The Workgro	October 2011
			FALSE	TRUE		February 2013
2.10	1.36	10,642	FALSE	FALSE		
1.89	1.10	3,012	FALSE	FALSE		
1.25	0.74	2,217	FALSE	FALSE		
0.66	0.41	5,963	FALSE	FALSE		
2.01	1.74	12,377	FALSE	TRUE	In October 2(	September 2021
2.50	2.12	35,798	FALSE	TRUE	In October 2(	September 2021
0.84	0.81	3,550	FALSE	TRUE	In October 2(	September 2021
1.00	0.94	5,293	FALSE	TRUE	In October 2(	September 2021
2.29	1.90	34,142	FALSE	TRUE	In October 2(	September 2021
3.24	2.53	45,496	FALSE	TRUE	In October 2(	September 2021
2.63	2.26	24,981	FALSE	TRUE	In October 2(	September 2021
3.70	3.04	23,176	FALSE	TRUE	In October 2(	September 2021
2.71	2.29	34,531	FALSE	TRUE	In October 2(	September 2021
3.68	2.81	39,373	FALSE	TRUE	In October 2(	September 2021
3.81	2.91	2,808	FALSE	TRUE	In October 2(	September 2021
4.12	2.94	2,320	FALSE	TRUE	In October 2(	September 2021
1.01	0.79	14,835	FALSE	TRUE	In October 2(	September 2021
1.62	1.34	9,241	FALSE	TRUE	In October 2(	September 2021
1.62	1.18	343	FALSE	TRUE	In October 2(	September 2021
2.24	1.42	100	FALSE	TRUE	In October 2(	September 2021
2.32	1.81	13,074	FALSE	FALSE		February 2013
0.98	0.90	1,497	FALSE	FALSE		February 2013
1.72	1.17	10,579	FALSE	FALSE		February 2013
0.83	0.62	4,688	FALSE	FALSE		February 2013
2.50	1.30	1,922	FALSE	FALSE		February 2013
2.58	1.41	8,635	FALSE	FALSE		February 2013
3.36	1.04	14,067	FALSE	FALSE		February 2013
4.14	1.26	12,731	FALSE	FALSE		February 2013
1.87	1.21	8,680	FALSE	FALSE		October 2015
0.73	0.70	760	FALSE	FALSE		October 2015
1.79	0.82	15,577	FALSE	FALSE		October 2015
0.76	0.48	3,865	FALSE	FALSE		October 2015
			FALSE	TRUE	A CCP was su	October 2014
			FALSE	TRUE	A CCP was su	October 2014
0.45	0.36	60,377	FALSE	FALSE	A CCP was su	October 2014
0.36	0.27	91,408	FALSE	FALSE	A CCP was su	October 2014
2.33	0.63	14,539	FALSE	FALSE		
13.67	7.33	33	FALSE	FALSE		February 2011
			FALSE	TRUE	The Workgro	February 2011
5.01	2.53	65	FALSE	TRUE	The RUC refe	February 2009
4.43	2.12	350	FALSE	FALSE		

2.08	1.03	14,709	FALSE			FALSE		
2.42	1.25	11,253	FALSE			FALSE		
2.69	0.91	934	FALSE			FALSE		
0.66	0.17	7,044	FALSE			FALSE		February 2016
0.66	0.09	12,465	FALSE			TRUE	Prior to the J	February 2016
0.69	0.11	120,998	FALSE			FALSE		February 2016
0.77	0.11	33,584	FALSE			FALSE		
5.90	1.30	571	FALSE			FALSE		
5.18	1.44	5,714	FALSE			FALSE		
5.87	1.49	17,981	FALSE			FALSE		
8.67	2.38	2,251	FALSE			FALSE		
0.23	0.09	33,143	FALSE			FALSE		
			FALSE			TRUE	Referred to C	October 2014
2.30	1.25	535	FALSE			FALSE	Referred to C	October 2014
2.87	1.65	4,086	FALSE			FALSE	Referred to C	October 2014
0.68	0.13	32,762	FALSE			FALSE		
4.60	0.71	355	TRUE	Nov 2016	yes	FALSE		
2.19	0.13	2,390	FALSE			FALSE		
2.97	0.25	1,609	FALSE			FALSE		
1.36	0.13	10,517	FALSE			FALSE		
2.85	0.25	5,703	FALSE			FALSE		
3.54	0.14	1,264	FALSE			FALSE		
7.42	0.47	350	FALSE			FALSE		
9.13	1.34	518	FALSE			FALSE		
11.16	2.42	5,439	FALSE			FALSE		
12.21	2.75	1,561	FALSE			FALSE		
5.06	0.86	1,780	FALSE			FALSE		
1.65	0.36	2,988	FALSE			FALSE		
1.73	0.41	211	FALSE			FALSE		
1.72	0.39	210	FALSE			FALSE		
1.55	0.53	115	FALSE			FALSE		
1.83	0.43	569	FALSE			FALSE		
1.94	0.43	486	FALSE			FALSE		
0.65	0.23	1,136	FALSE			FALSE		
0.79	0.25	255	FALSE			FALSE		
0.92	0.21	5,390	FALSE			FALSE	Several speci	May 2012
1.04	0.23	220	FALSE			FALSE	Several speci	May 2012
1.05	0.22	2,578	FALSE			FALSE	Several speci	May 2012
1.35	0.25	13	FALSE			FALSE	Several speci	May 2012
1.40	0.26	159	FALSE			FALSE	Several speci	May 2012
1.33	0.25	21	FALSE			FALSE		
2.17	0.45	99	FALSE			FALSE		
1.57	0.56	585	FALSE			FALSE		
2.24	0.68	187	FALSE			FALSE		
1.78	0.43	215	FALSE			FALSE		
1.33	0.34	989	FALSE			FALSE	Several speci	May 2012
1.33	0.26	195	FALSE			FALSE	Several speci	May 2012

1.56	0.30	53	FALSE			FALSE	Several speci May 2012
			FALSE			FALSE	Several speci May 2012
1.18	0.26	2,069	FALSE			FALSE	Several speci May 2012
1.23	0.33	1,841	FALSE			FALSE	Several speci May 2012
1.58	0.33	191	FALSE			FALSE	Several speci May 2012
			FALSE			FALSE	Several speci May 2012
1.83	0.42	2,331	FALSE			FALSE	
1.55	0.28	502	FALSE			FALSE	Several speci May 2012
1.83	0.37	435	FALSE			FALSE	Several speci May 2012
2.03	0.59	1,577	FALSE			FALSE	October 2012
			FALSE			TRUE	Several speci February 2012
1.23	0.25	323,621	FALSE			FALSE	Several speci October 2012
1.37	0.26	16,281	TRUE	Apr 2009 a	Yes	FALSE	Several speci October 2012
1.85	0.37	18,922	FALSE			TRUE	In the Panel A February 2013
2.15	0.45	14,141	FALSE			TRUE	In the Panel A February 2013
1.37	0.26	########	FALSE			FALSE	Several specific codes identified
3.48	0.76	1,002	FALSE			TRUE	In the Panel A February 2013
1.36	0.28	4,312	FALSE			FALSE	Several speci October 2012
2.41	0.49	26,340	TRUE	Mar 2009	Yes	TRUE	In the Panel A February 2013
2.14	0.48	647	FALSE			FALSE	Several speci October 2012
2.26	0.46	22,233	FALSE			FALSE	Several speci October 2012
1.64	0.42	15,047	FALSE			FALSE	Several speci October 2012
1.78	0.49	71,081	FALSE			FALSE	Several speci October 2012
1.67	0.37	28,637	FALSE			FALSE	Several speci October 2012
1.60	0.32	110,879	FALSE			FALSE	Several speci October 2012
1.49	0.31	125,878	FALSE			FALSE	Several speci October 2012
1.58	0.43	3,775	FALSE			FALSE	Several speci October 2012
1.84	0.39	35,888	FALSE			FALSE	Several speci October 2012
2.41	0.49	2,309	FALSE			TRUE	In the Panel A February 2013
2.46	0.52	5,797	FALSE			FALSE	October 2012
1.88	0.39	62,091	FALSE			FALSE	Several speci October 2012
			FALSE			FALSE	Several speci October 2012
2.11	0.49	148	FALSE			FALSE	Several speci October 2012
			FALSE			FALSE	Several speci October 2012
2.10	0.43	34,294	TRUE	Mar 2009	Yes	TRUE	In the Panel A February 2013
2.90	0.63	4,795	FALSE			TRUE	Several speci February 2013
3.04	0.65	7,154	FALSE			FALSE	Several speci January 2013
3.19	0.70	30,450	FALSE			FALSE	Several speci January 2013
3.15	0.74	67	FALSE			FALSE	Several speci February 2013
3.25	0.71	56,121	FALSE			FALSE	Several speci February 2013
3.83	0.85	2,820	FALSE			FALSE	Several speci February 2013
1.93	0.48	5,767	FALSE			FALSE	October 2012
			FALSE			FALSE	Several speci February 2013
			FALSE			FALSE	Several speci February 2013
			FALSE			FALSE	Several speci February 2013
2.08	0.44	20,628	FALSE			FALSE	October 2012
			FALSE			FALSE	Several speci February 2013

			FALSE	FALSE	Several speci	February 2013
1.00	0.25	8,668	FALSE	FALSE	Several speci	February 2013
4.07	0.92	43,064	FALSE	FALSE		February 2013
3.35	0.74	14,287	FALSE	FALSE		February 2013
4.24	0.94	16,434	FALSE	FALSE		February 2013
3.37	0.74	6,694	FALSE	FALSE		February 2013
3.81	0.85	600	FALSE	FALSE		February 2013
0.88	0.15	71,670	FALSE	FALSE		
0.93	0.16	1,698	FALSE	FALSE	Several speci	May 2012
			FALSE	FALSE	Several speci	October 2012
			FALSE	FALSE	Several speci	October 2012
			FALSE	TRUE	In April 2017,	September 2017
0.23	0.13	49,049	FALSE	FALSE		
0.81	0.25	1,711	FALSE	FALSE		
14.94	6.28	10,216	FALSE	FALSE		
11.62	4.64	12,383	FALSE	FALSE		
15.07	6.16	9,951	FALSE	FALSE		
0.67	0.10	2,038	FALSE	FALSE	Several speci	May 2013
0.88	0.17	150	FALSE	FALSE		May 2013
0.83	0.14	1,549	FALSE	FALSE	Several speci	May 2013
			FALSE	FALSE	Several speci	May 2013
1.30	0.34	124	FALSE	FALSE		May 2013
0.74	0.15	1,312	FALSE	FALSE	Several speci	May 2013
0.91	0.17	1,832	FALSE	FALSE	Several speci	May 2013
1.45	0.39	4,180	FALSE	TRUE	Several speci	October 2013
1.61	0.38	2,551	FALSE	TRUE	Several speci	October 2013
1.97	0.41	18	FALSE	TRUE	Several speci	October 2013
2.12	0.46	159	FALSE	TRUE	Several speci	October 2013
1.76	0.49	297	FALSE	TRUE	Several speci	October 2013
			FALSE	TRUE	Several speci	October 2013
2.03	0.49	2,081	FALSE	TRUE	Several speci	October 2013
			FALSE	TRUE	Several speci	October 2013
2.24	0.46	65	FALSE	TRUE		October 2013
2.40	0.49	4	FALSE	FALSE		October 2013
2.75	0.59	76	FALSE	TRUE		October 2013
1.61	0.37	190	FALSE	TRUE		October 2013
1.75	0.34	57	FALSE	TRUE		October 2013
2.13	0.44	4	FALSE	TRUE		October 2013
2.51	0.53		FALSE	TRUE		October 2013
2.15	0.45	76	FALSE	TRUE		October 2013
			FALSE	FALSE	Deleted nine	October 2012
6.13	2.24	22,448	FALSE	FALSE		
			FALSE	TRUE	CPT code 451	October 2008
8.72	1.49	2,516	FALSE	FALSE		
10.18	2.05	1,918	FALSE	FALSE		
0.48	0.13	23,267	FALSE	FALSE		
0.67	0.11	50,795	FALSE	FALSE	Several speci	May 2013

0.81	0.14	36,318	FALSE			FALSE	Several speci	May 2013
1.07	0.22	353	FALSE			FALSE	Several speci	May 2013
0.97	0.21	734	FALSE			FALSE	Several speci	May 2013
1.19	0.22	3,411	FALSE			FALSE	Several speci	May 2013
0.76	0.14	3,141	FALSE			FALSE	Several speci	May 2013
0.99	0.26	1,691	FALSE			FALSE	Several speci	May 2013
1.20	0.25	5,383	FALSE			FALSE	Several speci	May 2013
			FALSE			FALSE	Several speci	May 2013
0.85	0.16	1,316	FALSE			FALSE	Several speci	May 2013
1.25	0.23	2,713	FALSE			TRUE	Several speci	October 2013
1.64	0.32	374	FALSE			TRUE	Several speci	October 2013
			FALSE			FALSE	Several speci	May 2013
1.54	0.32	1,183	FALSE			FALSE		May 2013
1.47	0.30	637	FALSE			FALSE		May 2013
1.86	0.39	632	FALSE			TRUE		October 2013
1.04	0.21	1,214	FALSE			TRUE		October 2013
			FALSE			FALSE	Several speci	February 2014
1.73	0.41	345,987	FALSE			TRUE	Several speci	October 2013
2.17	0.49	930	FALSE			TRUE	Several speci	October 2013
1.87	0.42	########	FALSE			TRUE	Several speci	October 2013
1.87	0.42	82,892	TRUE	Jun 2010	Yes	TRUE	Several speci	October 2013
2.36	0.51	24,121	FALSE			TRUE	Several speci	October 2013
			FALSE			TRUE	Several speci	October 2013
2.01	0.56	77,739	FALSE			TRUE	Several speci	October 2013
2.31	0.51	971,282	FALSE			TRUE	Several speci	October 2013
1.94	0.45	2,321	FALSE			TRUE	Several speci	October 2013
			FALSE			TRUE	Several speci	October 2013
2.41	0.59	26,744	FALSE			FALSE		October 2013
2.60	0.59	420	FALSE			FALSE		October 2013
2.98	0.64	23,129	FALSE			FALSE		October 2013
2.36	0.48	932	FALSE			TRUE	Several speci	October 2013
2.74	0.63	86	FALSE			TRUE	Several speci	October 2013
2.10	0.59	2,112	FALSE			FALSE		October 2013
2.06	0.59	3,509	FALSE			FALSE		October 2013
3.50	0.53	1,325	FALSE			FALSE		
1.17	0.21	339	FALSE			FALSE		
5.72	0.62	992	FALSE			FALSE		
3.53	0.26	12,575	FALSE			FALSE		
			FALSE			FALSE	Deleted nine	October 2012
46.85	21.53	1,590	FALSE			FALSE		
			FALSE			TRUE	Identified as	October 2014
5.04	1.34	3,121	FALSE			FALSE		
4.55	0.42	12,075	FALSE			TRUE	This service v	June 2009
			FALSE			TRUE	The Joint Wo	February 2015
			FALSE			TRUE	The Joint Wo	February 2015
			FALSE			TRUE	The Joint Wo	February 2015
			FALSE			TRUE	The Joint Wo	February 2015

			FALSE	FALSE		February 2015
			FALSE	FALSE		February 2015
0.62	0.13	8,621	FALSE	FALSE		February 2015
1.49	0.42	549	FALSE	FALSE		February 2015
1.79	0.48	1,518	FALSE	FALSE		February 2015
2.42	0.65	4,467	FALSE	FALSE		February 2015
1.35	0.34	438	FALSE	FALSE		February 2015
0.96	0.23	14,577	FALSE	FALSE		February 2015
0.77	0.16	1,737	FALSE	FALSE		February 2015
1.62	0.43	1,025	FALSE	FALSE		February 2015
2.55	0.82	135	FALSE	FALSE		February 2015
2.84	0.80	223	FALSE	FALSE		February 2015
2.22	0.64	170	FALSE	FALSE		February 2015
0.82	0.25	1,346	FALSE	FALSE		February 2015
0.89	0.26	692	FALSE	FALSE		February 2015
0.93	0.30	322	FALSE	TRUE	The committ	February 2015
			FALSE	FALSE		
6.54	2.53	100,881	FALSE	FALSE		
7.04	2.75	38,983	FALSE	FALSE		
10.02	4.14	8,195	FALSE	FALSE		
10.45	4.42	1,408	FALSE	FALSE		
1.75	0.42	960	FALSE	FALSE		
			FALSE	FALSE	Deleted nine	October 2012
			FALSE	FALSE	Deleted nine	October 2012
			FALSE	FALSE	Deleted nine	October 2012
			FALSE	FALSE	Deleted nine	October 2012
			FALSE	TRUE	The specialty	June 2010
			FALSE	FALSE		June 2010
0.72	0.17	11,210	FALSE	FALSE		June 2010
0.91	0.17	265,269	FALSE	FALSE		June 2010
0.75	0.42	1,879	FALSE	FALSE		June 2010
1.32	0.34	5,880	FALSE	FALSE	Deleted nine	October 2012
1.32	0.34	33,397	FALSE	FALSE	Deleted nine	October 2012
1.36	0.42	243	FALSE	FALSE	Deleted nine	October 2012
1.50	0.39	6,497	FALSE	FALSE		February 2010
			FALSE	TRUE	At the April 2	February 2010
1.53	0.96	1,848	FALSE	TRUE	At the April 2	February 2010
1.62	0.91	12,368	FALSE	FALSE		
5.60	1.92	50,710	FALSE	FALSE		
6.12	2.16	10,329	FALSE	FALSE		
7.00	2.74	1,809	FALSE	FALSE		
7.46	2.90	5,211	FALSE	TRUE	In October 2(	February 2021
5.37	1.69	7,947	FALSE	FALSE		
7.26	2.85	9,327	FALSE	FALSE		
9.02	3.60	5,848	FALSE	FALSE		
7.95	3.28	7,253	FALSE	FALSE		
9.73	4.03	4,804	FALSE	FALSE		

			FALSE			FALSE	Deleted nine	October 2012
7.75	1.82	2,659	FALSE			TRUE	In January 20	May 2021
10.97	2.71	5,937	FALSE			TRUE	In January 20	May 2021
1.10	0.21	38,395	FALSE			FALSE		
22.26	9.28	12,479	FALSE			FALSE		
0.51	0.15	7,721	FALSE			FALSE		October 2014
			FALSE			TRUE	The Joint Wo	October 2014
			FALSE			TRUE	The Joint Wo	October 2014
			FALSE			TRUE	The Joint Wo	October 2014
			FALSE			TRUE	In January 20	September 2017
			FALSE			TRUE	The Joint Wo	October 2014
1.28	0.27	1,007	FALSE			FALSE		October 2014
0.69	0.10	8,818	FALSE			FALSE		October 2014
1.57	0.34	28,285	FALSE			FALSE		October 2014
1.85	0.45	5,572	FALSE			FALSE		
1.45	0.33	2,477	FALSE			FALSE		October 2014
0.89	0.15	46,684	FALSE			FALSE		October 2014
1.31	0.27	607	FALSE			FALSE		
1.93	0.45	1,196	FALSE			FALSE		
10.11	2.54	197	FALSE			FALSE		
10.78	3.01	2,422	FALSE			FALSE		
5.72	1.14	54,658	FALSE			FALSE		
9.05	3.52	3,602	TRUE	Dec 2009	Yes	FALSE		
0.91	0.27	104	FALSE			TRUE		October 2014
1.58	0.34	4,504	FALSE			FALSE		October 2014
1.99	0.45	981	FALSE			FALSE		October 2014
2.52	0.59	1,321	FALSE			FALSE		October 2014
0.65	0.41	65	FALSE			TRUE		October 2014
1.11	0.34	1,459	FALSE			TRUE		October 2014
3.48	0.52	5,029	FALSE			FALSE		
1.23	0.28	14,265	FALSE			FALSE		
0.21	0.09	194,801	FALSE			FALSE		
0.18	0.06	168,108	FALSE			FALSE		
0.18	0.05	234,004	FALSE			FALSE		
0.58	0.17	54,647	FALSE			FALSE		
0.30	0.10	160,447	FALSE			FALSE		
NA	0.17	4,438	FALSE			TRUE	Referred to t	February 2009
NA	0.22	1,982	FALSE			FALSE		
NA	0.19	85,150	FALSE			FALSE		
NA	0.27	61,880	FALSE			FALSE		
NA	0.02	10,797	FALSE			FALSE		
NA	0.03	423,494	FALSE			FALSE		
			FALSE			TRUE	Referred to t	February 2009
NA	0.07	142,000	TRUE	Feb 2014	Yes	TRUE	The Joint Wo	February 2014
NA	0.11	7,152	TRUE	Feb 2014	Yes	TRUE	The Joint Wo	February 2014
			FALSE			TRUE	Referred to t	February 2009
NA	0.06	116,064	FALSE			TRUE	Referred to t	February 2009

NA	0.01	########	FALSE			FALSE	
0.63	0.17	897,375	FALSE			FALSE	
1.20	0.42	16,853	TRUE	Aug 2009 a	Yes	FALSE	
1.39	0.46	36,291	TRUE	Aug 2009 a	Yes	FALSE	
1.96	0.53	28,317	TRUE	May 2016	Yes	FALSE	
2.27	0.64	33,411	TRUE	May 2016	Yes	FALSE	
2.98	0.86	21,956	TRUE	May 2016	Yes	FALSE	
1.33	0.32	62,618	FALSE			FALSE	
1.32	0.39	51,037	FALSE			FALSE	
1.35	0.33	151,015	FALSE			TRUE	The Joint Wo February 2013
1.54	0.39	289	FALSE			FALSE	
2.24	0.63	2,487	FALSE			FALSE	
2.41	0.68	191	FALSE			FALSE	
2.65	0.74	21	FALSE			FALSE	
2.82	0.80	3,393	FALSE			FALSE	
3.00	0.86	480	FALSE			FALSE	
3.35	0.99	212	FALSE			FALSE	
2.34	0.66	22,929	FALSE			FALSE	
2.72	0.77	24,811	FALSE			FALSE	
2.98	0.86	11,180	FALSE			TRUE	The Joint Wo February 2013
3.15	0.93	9,144	FALSE			FALSE	
3.49	1.03	1,007	FALSE			FALSE	
3.11	0.93	78,507	FALSE			FALSE	
4.19	1.00	115	FALSE			FALSE	
0.35	0.13		FALSE			FALSE	
5.24	0.94	3,173	FALSE			FALSE	
6.56	1.51	44,942	FALSE			FALSE	
3.98	0.54	1,396	FALSE			FALSE	
6.60	1.42	18,059	FALSE			FALSE	
7.55	1.50	2,071	FALSE			FALSE	
4.25	0.64	2,363	FALSE			FALSE	
7.40	1.66	5,217	FALSE			FALSE	
8.22	1.76	1,286	FALSE			FALSE	
3.61	0.68	2,671	FALSE			FALSE	
5.37	1.02	1,190	FALSE			FALSE	
1.00	0.28	156,362	FALSE			FALSE	
3.95	0.70	2,297	FALSE			FALSE	
10.22	2.48	1,610	FALSE			FALSE	
10.24	2.52	150	FALSE			FALSE	
11.53	2.91	1,030	FALSE			FALSE	
12.05	3.10	20,334	FALSE			TRUE	The specialty society reported th
7.11	1.57	1,648	FALSE			FALSE	
7.66	1.41	6,399	FALSE			FALSE	
2.65	0.47	3,187	FALSE			FALSE	
8.20	1.20	3,143	FALSE			FALSE	
0.19	0.09	24,482	FALSE			FALSE	
2.64	0.43	3,111	FALSE			TRUE	ACOG condu October 2009

1.47	0.20	15,369	FALSE	FALSE		October 2009
0.34	0.14	85,733	FALSE	FALSE		
6.44	1.46	9,026	FALSE	TRUE	In October 2(	September 2016
6.48	1.52	8,757	FALSE	TRUE	In October 2(	September 2016
7.67	2.00	9,740	FALSE	TRUE	In October 2(	September 2016
8.38	2.32	4,370	FALSE	TRUE	In October 2(	September 2016
7.05	1.74	7,042	FALSE	FALSE		
7.11	1.79	5,777	FALSE	FALSE		
8.93	1.56	1,737	FALSE	FALSE		
7.93	1.73	25,452	FALSE	FALSE		
9.10	2.52	9,468	FALSE	FALSE		
0.47	0.20	68,910	FALSE	FALSE		
0.30	0.13	672	FALSE	FALSE		
1.38	0.43	1,494	FALSE	FALSE		
1.96	0.65	47,694	FALSE	FALSE		
2.35	0.81	121	FALSE	FALSE		
2.55	0.92	44	FALSE	FALSE		
2.89	1.03	2,396	FALSE	FALSE		
1.88	0.64	206	FALSE	FALSE		
2.06	0.71	2,831	FALSE	FALSE		
6.43	2.03	761	FALSE	FALSE		
6.04	1.82	13,081	FALSE	FALSE		
			FALSE	FALSE	Deleted nine	October 2012
24.40	9.28	2,825	FALSE	FALSE		
5.67	3.60	1,615	FALSE	FALSE		
8.24	4.59	823	FALSE	FALSE		
0.83	0.47	29	FALSE	FALSE		
0.62	0.45	56	FALSE	FALSE		
3.05	1.96	666	FALSE	FALSE		
5.62	3.55	710	FALSE	FALSE		
1.26	0.81	1,138	FALSE	FALSE		
26.09	11.12	2,365	FALSE	FALSE		
6.25	4.37	1,266	FALSE	FALSE		
10.19	6.09	760	FALSE	FALSE		
24.53	10.63	89	FALSE	FALSE		
6.14	4.48	65	FALSE	FALSE		
8.11	5.58	36	FALSE	FALSE		
26.17	11.37	22	FALSE	FALSE		
6.36	4.60	13	FALSE	FALSE		
10.81	6.31	6	FALSE	FALSE		
7.47	2.05	7,841	FALSE	FALSE		
9.89	2.66	308	FALSE	FALSE		
9.81	3.84	437	FALSE	FALSE		
9.29	4.38	254	FALSE	FALSE		
11.24	5.33	120	FALSE	FALSE		
1.06	0.34	293	FALSE	TRUE	This code cha	October 2013
1.79	1.39	15,851	FALSE	FALSE		October 2009

1.41	0.45	18,750	FALSE			FALSE		October 2009
1.82	1.25	18,207	FALSE			FALSE		October 2009
			FALSE			FALSE		February 2008
			FALSE			TRUE	The specialty	October 2009
10.94	5.14	6,704	FALSE			FALSE		
1.68	1.29	8,122	FALSE			FALSE		
13.63	7.18	3,528	FALSE			FALSE		
2.30	1.76	570	FALSE			FALSE		
1.41	0.82	5,499	FALSE			FALSE		
7.30	2.14	5,787	FALSE			TRUE	In Feb 2009,	October 2009
3.59	0.45	302	FALSE			FALSE		
0.41	0.16	79,126	FALSE			TRUE	In January 20	September 2018
0.65	0.34	6,301	FALSE			FALSE		September 2018
1.76	0.25	390	TRUE	Q&A May	Yes	FALSE		
0.77	0.17	16,213	FALSE			TRUE	Joint Workgr	October 2013
6.85	1.07	166	FALSE			FALSE		
1.51	0.27	7,115	TRUE	Mar 2011	Yes	FALSE		
1.00	0.20	4,191	FALSE			TRUE	Joint Workgr	October 2013
1.00	0.20	411	FALSE			TRUE	Joint Workgr	October 2013
0.99	0.20	18,417	FALSE			TRUE	Joint Workgr	October 2013
1.03	0.20	6,616	FALSE			TRUE	Joint Workgr	October 2013
			FALSE			TRUE	In the NPRM	May 2015
			FALSE			TRUE	In the NPRM	May 2015
			FALSE			TRUE	In the NPRM	May 2015
			FALSE			TRUE	In the NPRM	May 2015
0.87	0.22	5,631	FALSE			FALSE		May 2015
1.00	0.19	217,240	FALSE			FALSE		May 2015
0.65	0.17	42,693	FALSE			FALSE		May 2015
0.92	0.17	699,990	FALSE			FALSE		May 2015
0.56	0.15	19,559	FALSE			FALSE		May 2015
0.82	0.21	1,225	FALSE			FALSE		May 2015
0.58	0.15	4,644	FALSE			FALSE		May 2015
0.92	0.19	1,995	FALSE			FALSE		May 2015
0.62	0.23		FALSE			FALSE		September 2018
0.82	0.44		FALSE			FALSE		September 2018
4.53	1.15	5,884	FALSE			FALSE		
3.71	0.76	1,056	FALSE			FALSE		
4.12	0.99	242	FALSE			FALSE		
5.90	1.85	36	FALSE			FALSE		
4.53	1.24	8,146	FALSE			FALSE		
3.88	0.93	1,266	FALSE			FALSE		
0.19	0.05	10,982	FALSE			TRUE	Identified thr	October 2010
0.27	0.09	43,410	FALSE			TRUE	Identified thr	October 2010
0.28	0.09	31,581	FALSE			TRUE		October 2010
0.36	0.10	101,707	FALSE			TRUE		October 2010
11.67	3.96	27,404	FALSE			TRUE	CPT code 63(	May 2021
14.29	5.17	10,851	FALSE			FALSE		

14.22	5.84	10,977	FALSE			FALSE		
13.73	5.30	4,057	FALSE			FALSE		
12.73	4.53	101,838	FALSE			FALSE		
1.72	1.02	128,927	FALSE			FALSE		
15.52	6.63	6,048	TRUE	Oct 2009	Yes	TRUE	The specialty	February 2010
14.62	5.84	428	FALSE			TRUE	Referred to t	October 2009
1.99	1.15	313	FALSE			FALSE		October 2009
19.02	7.77	719	FALSE			TRUE	In January 20	September 2016
11.77	5.77	492	FALSE			FALSE		
1.92	1.47	160	FALSE			FALSE		
4.24	0.76	92,083	FALSE			FALSE		
10.29	3.48	8,801	FALSE			FALSE		
			FALSE			TRUE	The RUC recc	October 2008
3.61	0.90	3,832	FALSE			FALSE		
10.47	3.55	2,414	FALSE			FALSE		
4.47	1.04	1,584	FALSE			FALSE		
10.73	3.76	692	FALSE			FALSE		
4.42	1.07	29,921	TRUE			FALSE		
4.54	1.13	8,593	FALSE			FALSE		
0.42	0.21	134,871	FALSE			FALSE		
			TRUE	FAQ Sept 2	Yes	TRUE	In April 2013,	October 2014
0.38	0.11	199,150	TRUE	Dec 2011 &	Yes	TRUE	During the O	May 2021
0.27	0.13	17,912	FALSE			TRUE	During the O	May 2021
0.39	0.11	15,765	FALSE			TRUE	During the O	May 2021
0.44	0.14	31,818	FALSE			FALSE		
0.47	0.10	130,719	TRUE	Dec 2011 &	Yes	FALSE		
0.25	0.11	5,880	FALSE			TRUE	During the O	May 2021
0.35	0.09	282,703	TRUE	Dec 2011 &	Yes	TRUE	During the O	May 2021
0.25	0.11	40,188	FALSE			TRUE	During the O	May 2021
0.42	0.13	1,957	FALSE			TRUE	The RUC recc	February 2008
0.40	0.09	467,316	TRUE	Jan 2013	Yes	FALSE		
0.18	0.05	74,450	FALSE			FALSE		
0.35	0.15	4,096	TRUE	Jan 2016	Yes	FALSE		
0.24	0.09	1,483	TRUE	Jan 2016	Yes	FALSE		
0.35	0.15	1,514	TRUE	Jan 2016	Yes	FALSE		
			FALSE			TRUE	The RUC recc	February 2009
			FALSE			TRUE	The RUC recc	February 2009
			FALSE			TRUE	The RUC recc	February 2009
			FALSE			TRUE	The RUC recc	February 2009
1.32	0.21	44,367	FALSE			TRUE	The RUC recc	June 2009
0.49	0.13	19,219	FALSE			TRUE	The RUC recc	June 2009
1.18	0.17	########	FALSE			TRUE	The RUC recc	June 2009
0.42	0.10	431,178	FALSE			TRUE	The Workgro	June 2009
1.08	0.19	265,103	FALSE			FALSE		
0.47	0.13	239,462	FALSE			FALSE		
0.50	0.13	156,746	FALSE			FALSE		
0.97	0.15	901,171	FALSE			FALSE		

0.41	0.10	809,666	FALSE			FALSE		
0.43	0.10	456,363	FALSE			FALSE		
0.90	0.13	6,436	FALSE			FALSE		
0.97	0.14	18,919	FALSE			FALSE		
			FALSE			TRUE	In Septembe	June 2017
3.71	0.77	484	FALSE			TRUE	The RUC disc	September 2016
3.42	0.77	3,342	TRUE	Jan 2016	Yes	TRUE	The RUC disc	September 2016
2.74	0.69	14,987	FALSE			FALSE		September 2016
			FALSE			FALSE		September 2016
0.21	0.09	201,680	FALSE			FALSE		
6.98	2.22	1,002	FALSE			FALSE		October 2009
			FALSE			TRUE	In Feb 2009,	October 2009
5.51	1.59	10,284	FALSE			FALSE		
1.92	0.34	12,197	FALSE			TRUE	In October 2017, this service was	
1.18	0.59	143,888	FALSE			FALSE		
			FALSE			TRUE	The Executive	June 2008 and Feb
			FALSE			TRUE	The Executive	June 2008 and Feb
			FALSE			TRUE	The Executive	June 2008 and Feb
			FALSE			TRUE	The Executive	June 2008 and Feb
2.35	0.37	86,013	TRUE	February 2	Yes	TRUE	In February 2	May 2015
0.53	0.13	135,589	TRUE	February 2	Yes	TRUE	In February 2	May 2015
2.33	0.36	358,450	TRUE	February 2	Yes	TRUE	In February 2	May 2015
0.47	0.11	539,040	TRUE	Feb 2015	Yes	TRUE	In February 2	May 2015
1.29	0.19	184,562	FALSE			FALSE		
7.44	1.21	4,356	FALSE			FALSE		
7.85	1.61	705	FALSE			TRUE	The specialty	February 2010
9.58	1.62	878	FALSE			FALSE		
16.80	0.74	835	FALSE			FALSE		
0.32	0.04	26,275	FALSE			FALSE		
0.41	0.04	25,202	FALSE			FALSE		
0.58	0.05	24,544	FALSE			FALSE		
15.46	1.15	704	FALSE			FALSE		
10.94	0.59	1,974	TRUE	Jun 2009	Yes	FALSE		
0.95	0.13	20,137	FALSE			TRUE	Sept 2011 AA	October 2011
			FALSE			TRUE	Sept 2011 AA	October 2011
2.71	0.22	143,167	FALSE			TRUE	Referred to C	February 2015
16.61	1.03	6,957	FALSE			FALSE		
18.54	1.10	3,104	FALSE			FALSE		
13.35	0.96	10,214	FALSE			TRUE	In January 20	October 2020
13.88	1.02	223	FALSE			FALSE		
16.15	1.03	802	FALSE			TRUE		October 2013
16.76	1.13	10,715	FALSE			TRUE	In April 2013,	October 2013
15.57	0.99	4,674	FALSE			FALSE		
12.53	0.71	594	FALSE			TRUE		October 2013
13.16	0.78	1,600	FALSE			TRUE	In April 2013,	October 2013
8.58	0.43	7,616	FALSE			TRUE	In October 2(	May 2018
3.60	0.22	67,836	FALSE			TRUE	In April 2009	February 2010

5.36	0.25	685,933	FALSE			FALSE		
10.53	0.74	159,924	TRUE	Sep 2009	Yes	FALSE		
0.00	0.00	93	FALSE			FALSE		
7.83	0.53	########	FALSE			TRUE	In October 2(	May 2018
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
			FALSE			FALSE	At the April 2	October 2020
			FALSE			FALSE	At the April 2	October 2020
1.11	0.11	########	FALSE			FALSE		
12.84	0.92	18,016	FALSE			FALSE		
			FALSE			FALSE		February 2007
13.50	0.99	3,357	FALSE			FALSE		
14.31	1.10	8,666	FALSE			FALSE		
15.44	1.24	13,146	FALSE			FALSE		
15.44	1.24	26,972	FALSE			FALSE		
16.10	1.30	373	FALSE			FALSE		
4.45	0.26	343	FALSE			TRUE	In April 2015,	May 2015
4.29	0.25	3,778	FALSE			TRUE	In April 2015,	May 2015
15.23	1.19	623	FALSE			FALSE	CPT codes 67	October 2014
15.93	1.28	16,523	FALSE			FALSE	CPT codes 67	October 2014
12.46	0.75	2,305	FALSE			FALSE	CPT codes 67	October 2014
			FALSE			TRUE	Added as par	October 2014
17.96	1.44	12,384	FALSE			FALSE	CPT codes 67	October 2014
7.41	0.45	1,395	FALSE			TRUE	CPT code 671	May 2020
7.52	0.47	31,865	FALSE			TRUE	CPT code 671	May 2020
7.54	0.47	56,884	FALSE			TRUE	Code originally referred to CPT w	
7.54	0.47	3,636	FALSE			TRUE	Code originally referred to CPT w	
0.29	0.04	168	FALSE			FALSE		
4.04	0.33	62,152	FALSE			FALSE		
10.83	0.64	833	FALSE			TRUE		October 2013
8.90	0.59	4,955	FALSE			FALSE		
10.47	0.74	1,514	FALSE			FALSE		
10.32	0.65	2,533	FALSE			FALSE		
11.62	0.80	168	FALSE			FALSE		
10.86	0.68	205	FALSE			FALSE		
3.31	0.42	362	FALSE			FALSE		
3.15	0.39	902	FALSE			FALSE		
3.41	0.43	1,753	FALSE			FALSE		
3.11	0.38	128	FALSE			FALSE		
1.52	0.19	1,681	FALSE			FALSE		
3.71	0.45	88	FALSE			FALSE		
0.52	0.09	7,903	FALSE			FALSE		
0.82	0.09	140	FALSE			FALSE		
0.56	0.05	24,360	FALSE			FALSE		
0.31	0.02	222,157	FALSE			FALSE		
5.40	0.30	1,601	FALSE			FALSE		
3.54	0.15	332	FALSE			FALSE		

6.46	0.45	1,895	FALSE			FALSE		
6.75	0.47	24,678	FALSE			FALSE		
5.25	0.26	3,614	FALSE			FALSE		
3.52	0.15	100	FALSE			FALSE		
6.48	0.43	1,300	FALSE			FALSE		
6.76	0.46	11,149	FALSE			FALSE		
0.49	0.04	6,702	FALSE			TRUE	AAO to deve	February 2013
0.46	0.04	8,059	FALSE			FALSE		
1.39	0.05	27,980	FALSE			FALSE		
2.02	0.13	28,019	FALSE			FALSE		
2.01	0.14	451	FALSE			FALSE		
3.49	0.21	8,129	FALSE			FALSE		
2.26	0.16	248	FALSE			FALSE		
0.46	0.09	164,973	FALSE			FALSE		
0.49	0.11	59,479	FALSE			FALSE		
0.27	0.09	########	FALSE			TRUE	In January 20	October 2012
			FALSE			TRUE	October 201	February 2014
			FALSE			TRUE	October 201	February 2014
			FALSE			TRUE	October 201	February 2014
2.03	0.21	48,248	FALSE			FALSE		
1.26	0.27	24,321	TRUE	May 2011	Yes	TRUE	The Workgro	Feb 2010
			FALSE			TRUE	Prior to surve	Feburary 2011
15.81	2.44	4,267	FALSE			FALSE		
NA	0.02	23,756	FALSE			FALSE		
NA	0.02	20,165	FALSE			FALSE		
NA	0.02	31,748	FALSE			FALSE		
NA	0.02	59,212	FALSE			FALSE		
NA	0.02	45,019	FALSE			FALSE		
NA	0.02	9,622	FALSE			FALSE		
NA	0.02	2,217	FALSE			FALSE		
NA	0.02	64,675	FALSE			FALSE		
NA	0.06	1,976	TRUE	July 2014	Yes	FALSE		
			TRUE	July 2014	Yes	FALSE		
NA	0.05	########	FALSE			FALSE		
NA	0.06	28,050	FALSE			FALSE		
NA	0.06	92,135	FALSE			FALSE		
NA	0.06	54,791	FALSE			FALSE		
NA	0.06	10,929	FALSE			FALSE		
NA	0.07	4,917	FALSE			FALSE		
NA	0.05	532,110	FALSE			FALSE		
NA	0.06	30,559	FALSE			FALSE		
NA	0.06	3,505	FALSE			FALSE		
NA	0.06	68,230	FALSE			FALSE		
NA	0.06	279,888	FALSE			FALSE		
NA	0.10	25,867	FALSE			FALSE		
NA	0.11	525,192	FALSE			FALSE		
NA	0.11	546,880	FALSE			FALSE		

NA	0.07	10,325	FALSE			FALSE		
NA	0.11	993	FALSE			FALSE		
NA	0.12	61,843	FALSE			FALSE		
NA	0.07	247,119	FALSE			FALSE		
NA	0.07	3,638	FALSE			FALSE		
NA	0.10	18,220	FALSE			FALSE		
NA	0.07	78,876	FALSE			FALSE		
NA	0.08	17,524	FALSE			FALSE		
NA	0.13	58,959	FALSE			FALSE		
NA	0.08	########	FALSE			FALSE		
NA	0.11	21,951	FALSE			FALSE		
NA	0.13	########	FALSE			FALSE		
			FALSE			FALSE		February 2016
			FALSE			FALSE		February 2016
			FALSE			FALSE		February 2016
			FALSE			FALSE		February 2016
			FALSE			FALSE		February 2016
			FALSE			FALSE		February 2016
			FALSE			FALSE		February 2016
			FALSE			FALSE		February 2016
			FALSE			FALSE		February 2016
NA	0.02	########	FALSE			FALSE		February 2016
NA	0.02	########	FALSE			FALSE		February 2016
NA	0.02	15,324	FALSE			FALSE		February 2016
NA	0.02	10,897	FALSE			FALSE		February 2016
			FALSE			TRUE	33213 - This (	February 2011
NA	0.02	174,554	FALSE			FALSE		
NA	0.02	301,474	FALSE			FALSE		
NA	0.02	24,795	FALSE			FALSE		
NA	0.02	30,595	FALSE			FALSE		
NA	0.06	########	FALSE			FALSE		
NA	0.06	########	FALSE			FALSE		
NA	0.06	70,977	FALSE			FALSE		
NA	0.06		FALSE			FALSE		
NA	0.11	########	TRUE	Jun 2009	Yes	FALSE		
NA	0.02	145,820	FALSE			FALSE		
NA	0.02	641,468	FALSE			TRUE	The RUC recc	October 2011
NA	0.02	378,821	FALSE			TRUE	The RUC recc	October 2011
NA	0.02	80,862	FALSE			TRUE	The RUC recc	October 2011
NA	0.02	300,255	FALSE			FALSE		
NA	0.02	184,802	FALSE			FALSE		
NA	0.02	12,934	FALSE			FALSE		
NA	0.02	46,745	FALSE			FALSE		
NA	0.02	########	FALSE			TRUE	This service v	October 2010
NA	0.02	821,121	FALSE			TRUE	April 2010, re	October 2010
NA	0.02	96,261	FALSE			TRUE	This service v	October 2010
NA	0.02	52,798	FALSE			TRUE	Code 72110 \	October 2010

NA	0.06	########	FALSE			FALSE	
NA	0.06	20,553	FALSE			FALSE	
NA	0.06	1,798	FALSE			FALSE	
NA	0.06	199,533	FALSE			FALSE	
NA	0.06	26,437	FALSE			FALSE	
NA	0.06	1,318	FALSE			FALSE	
NA	0.06	519,043	FALSE			FALSE	
NA	0.06	61,654	FALSE			FALSE	
NA	0.06	4,078	FALSE			FALSE	
NA	0.07	600,156	FALSE			FALSE	
NA	0.11	3,391	FALSE			FALSE	
NA	0.07	223,500	FALSE			FALSE	
NA	0.11	3,124	FALSE			FALSE	
NA	0.07	########	FALSE			FALSE	
NA	0.11	5,622	FALSE			FALSE	
NA	0.13	120,879	FALSE			FALSE	
NA	0.13	98,889	FALSE			FALSE	
NA	0.13	244,364	FALSE			FALSE	
NA	0.02	792,294	FALSE			TRUE	The Joint Wo October 2014
NA	0.02	56,338	FALSE			FALSE	
NA	0.11	2,441	FALSE			TRUE	The Workgro October 2010
NA	0.06	183,953	FALSE			TRUE	The specialty October 2009
NA	0.06	37,206	FALSE			TRUE	The specialty October 2009
NA	0.07	5,552	FALSE			TRUE	Referred to t October 2009
NA	0.08	85,947	FALSE			FALSE	
NA	0.11	2,606	FALSE			FALSE	
NA	0.12	214,192	FALSE			FALSE	
NA	0.02	14,605	FALSE			FALSE	
NA	0.02	39,418	FALSE			FALSE	
NA	0.02	116,528	FALSE			FALSE	
NA	0.06	647	FALSE			TRUE	Joint Workgr October 2013
NA	0.11	125	FALSE			TRUE	This code cha October 2013
NA	0.05	3,681	FALSE			TRUE	Joint Workgr October 2013
NA	0.07	1,087	FALSE			TRUE	Joint Workgr October 2013
NA	0.05	66,516	TRUE	Oct 2009 a	Yes	TRUE	In October 2(October 2020
			FALSE			TRUE	Joint Workgr February 2014
			FALSE			TRUE	Joint Workgr February 2014
NA	0.02	100,682	FALSE			FALSE	
NA	0.02	51,052	FALSE			FALSE	
NA	0.02	119,144	FALSE			FALSE	
NA	0.02	########	FALSE			FALSE	
NA	0.02	8,123	FALSE			FALSE	
NA	0.02	341,436	FALSE			FALSE	
NA	0.02	219,794	FALSE			FALSE	
NA	0.02	404,093	FALSE			FALSE	
NA	0.02	230,897	FALSE			FALSE	
NA	0.02	274,134	FALSE			FALSE	

NA	0.02	########	FALSE			FALSE			
NA	0.02	278,753	FALSE			FALSE			
NA	0.02	########	FALSE			FALSE			
NA	0.02	388,288	FALSE			FALSE			
NA	0.06	126,320	FALSE			FALSE			
NA	0.06	21,360	FALSE			FALSE			
NA	0.07	1,982	FALSE			FALSE			
NA	0.13	6,543	FALSE			FALSE			
NA	0.07	33,624	TRUE	Feb 2011	Yes	FALSE			
NA	0.08	475,051	FALSE			FALSE			
			FALSE			TRUE	In Jan 2012, t	October 2014	
NA	0.02	285,022	FALSE			FALSE		October 2014	
NA	0.02	########	FALSE			FALSE		October 2014	
NA	0.02	46,804	FALSE			FALSE		October 2014	
			FALSE			FALSE		October 2014	
			FALSE			TRUE	CPT code 735	October 2014	
NA	0.02	158,149	FALSE			FALSE		October 2014	
NA	0.02	188,143	FALSE			FALSE		October 2014	
NA	0.02	107,476	FALSE			FALSE		October 2014	
			FALSE			FALSE		October 2014	
			TRUE	Deleted fr	Yes	TRUE	The RUC recc	February 2011	
			FALSE			TRUE	In Jan 2012, t	October 2014	
NA	0.02	37,871	FALSE			FALSE		October 2014	
NA	0.02	548,327	FALSE			FALSE		October 2014	
NA	0.02	########	FALSE			FALSE			
NA	0.02	########	FALSE			FALSE			
NA	0.02	########	FALSE			FALSE			
NA	0.02	207,121	FALSE			FALSE			
NA	0.06	30,453	TRUE	Jun 2012	Yes	TRUE	The Workgro	May 2021	
NA	0.02	500,593	FALSE			FALSE			
NA	0.02	240,693	FALSE			FALSE			
NA	0.02	########	FALSE			FALSE			
NA	0.02	574,129	FALSE			FALSE			
NA	0.02	########	FALSE			FALSE			
NA	0.02	81,836	FALSE			FALSE			
NA	0.02	120,091	FALSE			FALSE			
NA	0.06	338,278	FALSE			FALSE			
NA	0.06	47,637	FALSE			FALSE			
NA	0.06	4,842	FALSE			FALSE			
NA	0.13	16,508	FALSE			FALSE			
NA	0.07	148,143	FALSE			FALSE			
NA	0.11	1,344	FALSE			FALSE			
NA	0.12	64,864	FALSE			FALSE			
NA	0.08	670,662	FALSE			FALSE			
			FALSE			FALSE		February 2016	
			FALSE			FALSE		February 2016	
NA	0.02	########	FALSE			FALSE		February 2016	

NA	0.02	429,437	FALSE	FALSE		February 2016
			FALSE	FALSE		February 2016
NA	0.02	58,811	FALSE	FALSE		February 2016
NA	0.02	283,318	FALSE	FALSE		February 2016
NA	0.06	77,343	FALSE	TRUE	Referred to t	October 2009
NA	0.06	105,409	FALSE	TRUE	Referred to t	October 2009
NA	0.08	107,476	FALSE	TRUE	Referred to t	October 2009
NA	0.15	294,980	FALSE	FALSE		
NA	0.11	37,638	FALSE	TRUE	The ACR subr	October 2010
NA	0.10	########	FALSE	FALSE		October 2009
NA	0.11	########	FALSE	FALSE		October 2009
NA	0.11	534,971	FALSE	FALSE		October 2009
NA	0.07	117,420	FALSE	FALSE		
NA	0.11	4,286	FALSE	FALSE		
NA	0.12	354,840	FALSE	FALSE		
NA	0.05	1,577	FALSE	FALSE		
NA	0.05	196,573	FALSE	FALSE		
NA	0.05		FALSE	FALSE		
NA	0.05	370,056	FALSE	FALSE		
NA	0.05	53,309	FALSE	TRUE	In January 20	May 2018
		25,415	FALSE	TRUE	In January 20	May 2018
		12,946	FALSE	TRUE	In January 20	May 2018
NA	0.05	34,438	FALSE	TRUE	In January 20	May 2018
		21,591	FALSE	TRUE	In January 20	May 2018
NA	0.04		FALSE	TRUE	In January 20	February 2019-EC
		13,972	FALSE	TRUE	In January 20	May 2018
NA	0.05	52,021	FALSE	TRUE	In January 20	May 2018
NA	0.06	206	FALSE	TRUE	In January 20	May 2018
		24	FALSE	TRUE	In January 20	May 2018
NA	0.06	28,934	FALSE	TRUE	In January 20	May 2018
NA	0.06	8,205	FALSE	TRUE	In January 20	May 2018
NA	0.00	29,648	FALSE	FALSE		
NA	0.00	63	FALSE	FALSE		
			FALSE	TRUE	The Joint Wo	February 2015
			FALSE	TRUE	The Joint Wo	February 2015
			FALSE	FALSE		February 2015
NA	0.00	64,506	FALSE	FALSE		
NA	0.00	2,990	FALSE	FALSE		
NA	0.00	13,859	FALSE	FALSE		
NA	0.03	5,180	FALSE	FALSE		
NA	0.03	166,220	FALSE	FALSE		
NA	0.03	3,703	FALSE	TRUE	CPT code 744	September 2019
			FALSE	TRUE	The Joint Wo	October 2014
			FALSE	TRUE	The Joint Wo	October 2014
NA	0.03	1,628	FALSE	FALSE		
NA	0.13		FALSE	FALSE		
NA	0.08		FALSE	FALSE		

NA	0.14	86,531	FALSE			FALSE		
NA	0.20	96,916	FALSE			FALSE		
NA	0.22	27,465	FALSE			FALSE		
NA	0.17	114,472	FALSE			FALSE		
			FALSE			TRUE	The Workgro	February 2012
			FALSE			TRUE	The Workgro	February 2012
			FALSE			TRUE	The Workgro	February 2012
NA	0.23	157,614	TRUE			FALSE		
NA	0.23	74,926	FALSE			FALSE		
			FALSE			TRUE	The Workgro	February 2011
			FALSE			TRUE	The Workgro	February 2011
NA	0.15	41,396	FALSE			FALSE		
NA	0.10	77,363	FALSE			FALSE		
			FALSE			TRUE	Referred to t	February 2009
			FALSE			FALSE		October 2015
NA	0.10	23,689	FALSE			FALSE		
NA	0.14	10,692	FALSE			FALSE		
NA	0.10	348	FALSE			FALSE		
NA	0.10	525	FALSE			FALSE		
NA	0.00	9,539	FALSE			FALSE	The Workgro	RAW will assess Oc
			FALSE			TRUE	AANS indicat	February 2014 Feb
NA	0.00	11,637	TRUE	Septembe	complete	TRUE	The Workgro	February 2014 Feb
			FALSE			TRUE	The Workgro	February 2011
			FALSE			TRUE	A CCP was su	October 2014
			FALSE			TRUE	A CCP was su	October 2014
			FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
			FALSE			TRUE	In February 2	February 2013
			FALSE			TRUE	The Workgro	June 2011
			FALSE			TRUE	The Workgro	October 2015
			FALSE			TRUE	In February 2	October 2015
			FALSE			TRUE	In January 20	October 2015
			FALSE			TRUE	In January 20	October 2015
			FALSE			TRUE	CPT code 75	October 2015
			FALSE			TRUE	The Joint Wo	February 2015
			FALSE			TRUE	The Joint Wo	February 2015
NA	0.05	20,664	FALSE			FALSE	The Joint Wo	RAW will assess Oc
			FALSE			TRUE	The RUC recc	February 2010
			FALSE			TRUE	The RUC recc	February 2010
			FALSE			TRUE	The RUC recc	February 2010
			FALSE			TRUE	The RUC recc	February 2010
			FALSE			TRUE	The RUC recc	February 2010
NA	0.05	118,492	FALSE			FALSE		
			FALSE			TRUE	In April 2017	September 2017
NA	0.03	68,182	FALSE			FALSE		
NA	0.05	5,269	FALSE			FALSE		

NA	0.15	2	FALSE			FALSE		
NA	0.08	2,408	FALSE			FALSE		
NA	0.02	276,317	FALSE			FALSE		
NA	0.05	190,343	FALSE			TRUE	In the Final R	May 2021
NA	0.02	14,435	FALSE			FALSE		
NA	0.02	4,208	FALSE			FALSE		
NA	0.02	220,526	FALSE			FALSE		
NA	0.02	26,263	TRUE	Apr 2013	Yes	TRUE	At the April 2	September 2019
NA	0.02	488,963	FALSE			FALSE		
NA	0.02	2,403	FALSE			FALSE		
NA	0.02	187,253	FALSE			FALSE		
NA	0.05	945,181	FALSE			FALSE		
NA	0.05	106,091	FALSE			FALSE		
NA	0.05	647,984	FALSE			FALSE		October 2013
NA	0.05	769,119	FALSE			FALSE		October 2013
			FALSE			TRUE	Code 76645,	October 2013
NA	0.05	908,859	FALSE			FALSE		
NA	0.05	########	FALSE			FALSE		
NA	0.05	159,273	TRUE	Jan 2017	Yes	FALSE		May 2015
NA	0.05	########	FALSE			FALSE		
NA	0.05	522,183	FALSE			FALSE		
NA	0.05	12,225	FALSE			FALSE		
NA	0.05	442,342	FALSE			FALSE		
NA	0.05	429,962	FALSE			FALSE		
NA	0.03	205,984	FALSE			FALSE		
NA	0.05	147,467	FALSE			FALSE		
NA	0.03	212,765	FALSE			FALSE		
			FALSE			TRUE	The RUC recc	February 2010
NA	0.03	196,753	TRUE	Clinical Exa	Yes	TRUE	In February 2	June 2017
NA	0.03	288,120	TRUE	Clinical Exa	Yes	TRUE	In February 2	June 2017
		2,662	FALSE			FALSE		September 2018
NA	0.00	1,241	FALSE			FALSE		
NA	0.25	810	FALSE			FALSE		
NA	0.02	637,782	FALSE			FALSE		
NA	0.00	1,403	FALSE			FALSE		
NA	0.05	########	FALSE			TRUE	During the O	May 2021
NA	0.03	3	FALSE			FALSE		
			FALSE			TRUE	At the April 2	October 2013
NA	0.05	6,316	FALSE			FALSE		
		25,085	FALSE			TRUE	In October 2(	February 2020
NA	0.00	29,381	FALSE			TRUE	In October 2(	September 2021
NA	0.05	310,854	FALSE			TRUE	In the NPRM	October 2015
NA	0.05	528,759	FALSE			TRUE	In the NPRM	October 2015
NA	0.05	77,998	FALSE			TRUE	In the NPRM	October 2015
NA	0.10	4,582	FALSE			FALSE		
NA	0.10	210,656	FALSE			TRUE	In October 2(	February 2019
NA	0.05	########	FALSE			FALSE	Revise based on CMS input regar	

			FALSE			FALSE		October 2012
			FALSE			FALSE		October 2012
NA	0.08	367	FALSE			FALSE		June 2017
NA	0.08	4,029	FALSE			FALSE		June 2017
NA	0.12	1,164	FALSE			FALSE		June 2017
NA	0.13	87,710	FALSE			FALSE		June 2017
			FALSE			FALSE		October 2015
			FALSE			FALSE		October 2015
			FALSE			TRUE	In the NPRM	October 2015
			FALSE			TRUE	In the NPRM	October 2015
			FALSE			TRUE	In the NPRM	October 2015
			FALSE			TRUE	In preparatio	June 2017
			FALSE			TRUE	In preparatio	June 2017
NA	0.05	765,901	FALSE			FALSE		October 2015
NA	0.06	612,243	FALSE			FALSE		October 2015
NA	0.05	########	FALSE			FALSE		October 2015
NA	0.03	57,827	FALSE			FALSE		
NA	0.03	4,891	FALSE			FALSE		
NA	0.05	44,120	FALSE			FALSE		
NA	0.05	50	FALSE			FALSE		
NA	0.03	39,322	FALSE			FALSE		
			FALSE			TRUE	The Workgro	October 2010
NA	0.02	########	FALSE			TRUE	In Oct 2012, t	May 2013
NA	0.02	42,987	FALSE			FALSE		
			FALSE			TRUE	In Oct 2012, t	May 2013
			FALSE			TRUE	The Workgro	October 2010
NA	0.02	110,730	FALSE			FALSE	In Oct 2012, t	May 2013
NA	0.02	1,925	FALSE			FALSE	In Oct 2012, t	May 2013
0.67	0.09	9,135	FALSE			FALSE		
0.99	0.14	3,526	FALSE			FALSE		
1.51	0.22	297,484	FALSE			FALSE		
NA	0.05	370,105	FALSE			TRUE	ASTRO reviev	October 2012
NA	0.06	4,612	FALSE			TRUE	ASTRO reviev	October 2012
NA	0.07	210,211	FALSE			TRUE	ASTRO reviev	October 2012
NA	0.13	31,536	FALSE			FALSE		October 2012
NA	0.20	142,124	FALSE			TRUE	ASTRO reviev	October 2012, Oct
NA	0.03	########	FALSE			TRUE	On 8-21-12, t	February 2014, Oct
NA	0.56	143,270	TRUE	Nov 2009	Yes	FALSE		
			FALSE			TRUE	On 8-21-12, t	February 2014
NA	0.07	2,027	FALSE			FALSE		
NA	0.15	40,701	FALSE			FALSE		
			FALSE			TRUE	On 8-21-12, t	February 2014
			FALSE			TRUE	On 8-21-12, t	February 2014
NA	0.09	4,610	FALSE			FALSE		
NA	0.11	3,179	FALSE			FALSE		
NA	0.17	5,949	FALSE			TRUE	On 8-21-12, t	February 2014
			FALSE			TRUE	On 8-21-12, t	February 2014

			FALSE		TRUE	On 8-21-12, t	February 2014
			FALSE		TRUE	On 8-21-12, t	February 2014
NA	0.03	75,801	FALSE		FALSE		
NA	0.05	12,128	FALSE		FALSE		
NA	0.05	845,243	FALSE		FALSE		
NA	0.06	412,038	FALSE		FALSE		
NA	0.21	165,179	FALSE		FALSE		
0.00	0.00	100	FALSE		FALSE		
NA	0.15	818	FALSE		FALSE		
NA	0.21	33,144	FALSE		FALSE		
0.00	0.00		FALSE		FALSE		October 2013
0.00	0.00		FALSE		FALSE		October 2013
0.00	0.00		FALSE		FALSE		October 2013
NA	0.01	221,049	FALSE		TRUE	In October 2(	May 2019
0.00	0.00		FALSE		TRUE	At the April 2	October 2013 and
			FALSE		TRUE	At the April 2	October 2013
			FALSE		TRUE	At the April 2	October 2013
			FALSE		TRUE	At the April 2	October 2013
0.00	0.00		FALSE		TRUE	At the April 2	October 2013
			FALSE		TRUE	At the April 2	October 2013
			FALSE		TRUE	At the April 2	October 2013
			FALSE		TRUE	At the April 2	October 2013
0.00	0.00		FALSE		TRUE	At the April 2	October 2013
			FALSE		TRUE	At the April 2	October 2013
			FALSE		TRUE	At the April 2	October 2013
			FALSE		TRUE	At the April 2	October 2013
			TRUE	Nov 2009 a	Yes	TRUE	October 2013
			FALSE			TRUE	In Jan 2012, t	October 2013
			FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
1.88	0.25	########	FALSE			TRUE	In October 2(	June 2009
5.81	0.86	38,142	FALSE			FALSE		
NA	0.10	91,885	FALSE			FALSE		
0.00	0.00	256	FALSE			FALSE		
0.00	0.00	15,881	FALSE			FALSE		
0.00	0.00	47,302	FALSE			FALSE		
0.00	0.00	20,144	FALSE			FALSE		
NA	0.10	5,464	FALSE			FALSE		
NA	0.08	5,362	FALSE			FALSE		October 2014
NA	0.10	7,665	FALSE			FALSE		October 2014
NA	0.11	17,117	FALSE			FALSE		October 2014
NA	0.23	17,697	FALSE			FALSE		October 2014
NA	0.35	4,164	FALSE			FALSE		October 2014
			FALSE			FALSE		February 2015
			FALSE			FALSE		February 2015
NA	0.46	4,806	FALSE			TRUE	The Joint Wo	February 2015
			FALSE			TRUE	Deleted from	February 2008

			FALSE			TRUE	Deleted from	February 2008
			FALSE			TRUE	Deleted from	February 2008
rvices with Stand-Alone PE Proce			FALSE			TRUE	In October 2(	October 2014
rvices with Stand-Alone PE Proce			FALSE			TRUE	In October 2(	October 2014
			FALSE			TRUE	In October 2(	October 2014
NA	0.01	145	FALSE			TRUE	The Joint Wo	February 2015
			FALSE			TRUE	Identified wit	February 2012
			FALSE			TRUE	Identified wit	February 2012
			FALSE			TRUE	Identified wit	February 2012
			FALSE			TRUE	Identified wit	February 2012
			FALSE			TRUE	Specialty req	February 2012
			FALSE			TRUE	Identified wit	February 2012
			FALSE			TRUE	Identified wit	February 2012
NA	0.05	1,653	FALSE			TRUE	Identified wit	February 2012
NA	0.05	1,711	FALSE			TRUE	Identified wit	February 2012
NA	0.06	18,954	FALSE			TRUE	Identified wit	February 2012
NA	0.08	13,220	TRUE	Dec 2016	yes	FALSE		
NA	0.10	8,974	TRUE	Dec 2016	yes	FALSE		
NA	0.10	12,267	TRUE	Dec 2016	yes	FALSE		
			FALSE			TRUE	The specialtie	October 2010
NA	0.09	61,197	FALSE			FALSE		
NA	0.09	64,389	FALSE			FALSE		
NA	0.09	1,303	TRUE	Dec 2015	yes	FALSE		
NA	0.10	313	TRUE	Dec 2015	yes	FALSE		
NA	0.09	26,257	FALSE			FALSE		
NA	0.08	6,808	FALSE			FALSE		
NA	0.08	1,645	FALSE			FALSE		
NA	0.08	262,283	FALSE			FALSE		
NA	0.00		FALSE			FALSE		
NA	0.00		FALSE			FALSE		
NA	0.00		FALSE			FALSE		
NA	0.00		FALSE			FALSE		
NA	0.00		FALSE			FALSE		
NA	0.00		FALSE			FALSE		
NA	0.10	35,912	FALSE			FALSE		
NA	0.11	########	FALSE			FALSE		
NA	0.08	1,518	FALSE			FALSE		
NA	0.10	10,009	FALSE			FALSE		
NA	0.00	3,214	FALSE			FALSE		
			FALSE			FALSE		October 2008
			FALSE			FALSE		October 2008
			FALSE			FALSE		October 2008
			FALSE			TRUE	Referred to t	October 2008
NA	0.08	18,051	FALSE			FALSE		
			FALSE			TRUE	Referred to t	October 2008
			FALSE			TRUE	Referred to t	October 2008
NA	0.00	1,809	FALSE			FALSE		

NA	0.00	179,360	FALSE			TRUE	This service v	May 2018
NA	0.06	360	FALSE			TRUE		October 2010
NA	0.08	10,224	FALSE			TRUE	The specialtie	October 2010
NA	0.09	165,031	FALSE			TRUE		October 2010
			FALSE			TRUE	The specialtie	October 2010
			FALSE			TRUE	The specialtie	October 2010
			FALSE			TRUE	The specialtie	October 2010
			FALSE			TRUE	The specialtie	October 2010
			FALSE			TRUE	The specialtie	October 2010
			FALSE			TRUE	The specialtie	October 2010
			FALSE			TRUE	The specialtie	October 2010
			FALSE			TRUE	The specialtie	October 2010
			FALSE			TRUE	The specialtie	October 2010
NA	0.08	1,640	FALSE			FALSE		October 2010
NA	0.08	3,383	FALSE			TRUE		October 2010
NA	0.09	11,736	TRUE	Dec 2016	yes	FALSE		
NA	0.00	604,627	FALSE			FALSE		
NA	0.08	12,142	TRUE	Feb 2012	Yes	FALSE		
0.16	0.02	21,998	FALSE			TRUE	In October 2(	October 2020
0.60	0.06		FALSE			FALSE	In October 2(	October 2020
			FALSE			FALSE	In October 2(	October 2020
			FALSE			FALSE	In October 2(	October 2020
			FALSE			FALSE	In October 2(	October 2020
			FALSE			FALSE	In October 2(	October 2020
0.22	0.04	185,409	FALSE			FALSE		
0.42	0.05	140,727	FALSE			FALSE		
0.00	0.00	34,588	FALSE			FALSE		
NA	0.02	65,152	FALSE			FALSE		
NA	0.02	5,360	FALSE			FALSE		
			FALSE			TRUE	This service v	October 2010
NA	0.02	229,625	FALSE			FALSE		
NA	0.02	886,295	FALSE			FALSE	In January 2012 the specialty req	
NA	0.04	49,876	FALSE			FALSE		
NA	0.03	28,769	FALSE			FALSE		
0.36	0.01	55,857	FALSE			FALSE		
NA	0.02	8,020	FALSE			FALSE		
NA	0.02	4,156	FALSE			FALSE		
NA	0.03	1,306	FALSE			FALSE		
NA	0.02	104,681	FALSE			FALSE		
NA	0.00	########	FALSE			FALSE		
0.27	0.04	42,225	FALSE			FALSE		
0.55	0.05	38,197	FALSE			FALSE		
0.65	0.09	222,162	FALSE			FALSE		
NA	0.02	207,562	FALSE			FALSE		
NA	0.02	75,443	FALSE			FALSE		
NA	0.02	967,907	FALSE			FALSE		
NA	0.02	########	FALSE			FALSE		

NA	0.08	983,152	FALSE			FALSE		
NA	0.09	150,124	FALSE			FALSE		
NA	0.02	########	FALSE			TRUE	At the Februa	June 2010
NA	0.02	########	FALSE			TRUE	At the Februa	June 2010
NA	0.02	21,474	FALSE			TRUE	At the Februa	June 2010
			FALSE			TRUE	At the Februa	June 2010
NA	0.03	17,807	FALSE			TRUE	At the Februa	June 2010
0.71	0.09	182,148	FALSE			FALSE		
NA	0.03	35,000	FALSE			FALSE		
1.06	0.14	11,656	FALSE			FALSE		
0.32	0.04	27,870	FALSE			FALSE		
NA	0.03	448,638	FALSE			FALSE		
NA	0.02	163,257	FALSE			FALSE		
NA	0.03	69,359	FALSE			FALSE		
NA	0.01	31,996	FALSE			FALSE		
NA	0.01	########	FALSE			FALSE		
NA	0.02	########	FALSE			TRUE	In Jan 2012, t	May 2012
			FALSE			FALSE		
NA	0.02	132,224	FALSE			FALSE		
NA	0.02	61,000	FALSE			TRUE	In April 2013,	October 2014
			FALSE			TRUE	In April 2013,	October 2014
NA	0.09	17,170	FALSE			FALSE		
			FALSE			TRUE	Refer to CPT	Oct 2013
NA	0.02	260,841	FALSE			FALSE	In April 2013,	October 2014
NA	0.08	15,440	FALSE			FALSE		
NA	0.02	506,136	FALSE			FALSE		
NA	0.02	169,281	FALSE			FALSE		
NA	0.02	28,908	FALSE			FALSE		
NA	0.04	48,038	TRUE	Dec 2011 &	Yes	TRUE	In April 2013,	May 2013
NA	0.04	2,322	FALSE			FALSE		May 2013
NA	0.02	4,914	TRUE	Dec 2011 &	Yes	TRUE	In April 2013,	May 2013
NA	0.03	21,780	TRUE	Dec 2011 &	Yes	TRUE	In April 2013,	May 2013
NA	0.01	6,229	FALSE			FALSE		
NA	0.02	113,039	FALSE			FALSE		
NA	0.04	152,595	FALSE			FALSE		May 2013
			FALSE			FALSE		
			FALSE			FALSE		
NA	0.01	282,357	FALSE			FALSE		
NA	0.01	22,524	FALSE			FALSE		
NA	0.01	3	FALSE			FALSE		
NA	0.01	1	FALSE			FALSE		
0.04	0.01	408,566	FALSE			TRUE	In October 2(	October 2020
0.50	0.14	917,143	FALSE			TRUE	CPT February	February 2012
0.75	0.15	586,327	FALSE			TRUE	CPT February	February 2012
			FALSE			TRUE	January 2012	February 2012
			FALSE			TRUE	January 2012	February 2012
			FALSE			TRUE	January 2012	February 2012

			FALSE	TRUE	January 2012	February 2012
			FALSE	TRUE	January 2012	February 2012
0.22	0.05	########	FALSE	TRUE	CPT February	February 2012
0.27	0.05	########	FALSE	TRUE	CPT February	February 2012
0.28	0.09	########	FALSE	TRUE	CPT February	February 2012
0.34	0.06	510,888	FALSE	TRUE	CPT February	February 2012
0.42	0.13	########	FALSE	TRUE	CPT February	February 2012
0.46	0.10	100,884	FALSE	TRUE	CPT February	February 2012
0.41	0.13	23,040	FALSE	TRUE	CPT February	February 2012
0.19	0.05	6,284	FALSE	TRUE	CPT February	February 2012
0.31	0.09	5,591	FALSE	FALSE		
0.33	0.09	21,975	FALSE	TRUE	CPT February	February 2012
0.33	0.09	178,166	FALSE	TRUE	CPT February	February 2012
0.08	0.02	906,163	FALSE	TRUE	CPT February	February 2012
			FALSE	TRUE	January 2012	February 2012
0.19	0.04		FALSE	TRUE	CPT February	February 2012
0.00	0.00	238,754	FALSE	FALSE		
0.51	0.09	126,401	FALSE	FALSE		
		28,865	FALSE	TRUE	At the April 2	September 2018
0.31	0.05		FALSE	TRUE	In January 20	February 2019-EC
0.17	0.04		FALSE	TRUE	In January 20	February 2019-EC
0.53	0.09	########	FALSE	FALSE		
0.78	0.13	51,752	FALSE	FALSE		
0.83	0.10	165,382	FALSE	FALSE		
0.91	0.15	11,769	FALSE	FALSE		
8.88	1.55	17	FALSE	FALSE		
0.00	0.00	4	FALSE	FALSE		
0.00	0.00	1	FALSE	FALSE		
5.66	1.00	571	FALSE	FALSE		
4.37	0.62	57	FALSE	FALSE		
3.10	0.43	124	FALSE	FALSE		
6.19	0.96	1,539	FALSE	FALSE		
4.23	0.62	393	FALSE	FALSE		
2.93	0.38	292	FALSE	FALSE		
3.20	0.42	########	FALSE	FALSE		
2.75	0.33	719,245	FALSE	FALSE		
2.11	0.21	213,048	FALSE	FALSE		
4.93	0.74	229	FALSE	FALSE		
4.37	0.64	934	FALSE	FALSE		
4.26	0.62	1,343	FALSE	FALSE		
2.74	0.33	365,733	FALSE	FALSE		
NA	0.05	4,829	FALSE	FALSE		
NA	0.10	53,131	FALSE	FALSE		
NA	0.05	146	FALSE	FALSE		
NA	0.03	114	FALSE	FALSE		
NA	0.03	14	FALSE	FALSE		
NA	0.02	32,858	FALSE	TRUE	This service v	February 2021 Ma

NA	0.02	92,708	FALSE			FALSE		
NA	0.02	122,984	FALSE			FALSE		
NA	0.02	########	FALSE			FALSE		
0.32	0.02	31,551	FALSE			FALSE		
NA	0.02	########	FALSE			FALSE		October 2009
NA	0.02	########	FALSE			FALSE		October 2009
			FALSE			TRUE	Revise to spe	October 2009
NA	0.02	########	FALSE			FALSE		
			FALSE			TRUE	The specialty	May 2016
0.24	0.02		FALSE			FALSE		February 2018
0.15	0.01		FALSE			FALSE		February 2018
		947,451	FALSE			TRUE	A RUC memb	February 2018
		########	FALSE			FALSE		February 2018
NA	0.02	428,183	FALSE			TRUE	In January 20	October 2015
NA	0.06	10,668	FALSE			TRUE	In January 20	October 2015
NA	0.03	37,989	FALSE			TRUE	In January 20	October 2015
NA	0.02	########	FALSE			FALSE		
NA	0.02	2,435	TRUE	Aug 2008 a	Yes	TRUE	The specialtie	February 2014
NA	0.03	68,699	FALSE			FALSE		
NA	0.02	6,340	FALSE			FALSE		
			FALSE			TRUE	In January 20	June 2017
NA	0.03		FALSE			FALSE		
NA	0.02	406,118	FALSE			TRUE	The specialty	February 2010
NA	0.02	115,474	FALSE			TRUE	The specialty	October 2011
NA	0.03	7,182	TRUE	Mar 2013	Yes	TRUE	The specialty	October 2011
0.08	0.01	239,518	FALSE			FALSE		
			FALSE			TRUE	The specialty	October 2012
NA	0.05	350,653	FALSE			FALSE		
NA	0.01	4,438	FALSE			FALSE		
NA	0.09	197	FALSE			FALSE		October 2012
NA	0.10	3,374	FALSE			FALSE		October 2012
NA	0.15	19,962	FALSE			FALSE		October 2012
NA	0.09	18,441	FALSE			FALSE		October 2012
NA	0.05	133,424	FALSE			FALSE		
NA	0.02	68,931	FALSE			FALSE		October 2014
NA	0.02	6,794	FALSE			FALSE		October 2014
NA	0.05	89,363	FALSE			FALSE		
NA	0.02	13,573	FALSE			TRUE	Referred to t	February 2009
NA	0.02	19,332	FALSE			TRUE	Referred to t	February 2009
			FALSE			TRUE	The RUC disc	October 2014
NA	0.02	2,943	FALSE			TRUE	Referred to t	February 2009
NA	0.02	3,622	FALSE			TRUE	Referred to t	February 2009
NA	0.03	43,026	FALSE			TRUE	Referred to t	February 2014
NA	0.00	26,526	FALSE			TRUE	Referred to t	February 2014
NA	0.03	51,157	FALSE			TRUE	In 2014 the R	September 2018 /
NA	0.05		FALSE			FALSE		September 2018
NA	0.02	231,898	FALSE			FALSE		

0.31	0.04	########	FALSE			TRUE	Referred to t	February 2009
0.07	0.01		FALSE			FALSE		February 2011
0.10	0.01	922,916	FALSE			TRUE	Referred to t	February 2009
0.13	0.02	5,046	FALSE			TRUE	Referred to t	February 2009
			FALSE			TRUE	Referred to t	February 2009
0.28	0.04	38,849	FALSE			FALSE		
NA	0.05	11,016	FALSE			FALSE		
		34,565	FALSE			TRUE	In October 2(	February 2019
		1,425	FALSE			FALSE		February 2019
NA	0.02	58,068	FALSE			TRUE	The specialty	October 2010
NA	0.02	85,077	FALSE			FALSE		February 2011
NA	0.05	2,839	FALSE			FALSE		
0.68	0.14		FALSE			TRUE	The specialty	February 2011
0.54	0.13		FALSE			FALSE		
NA	0.06	544	FALSE			FALSE		
NA	0.04	220	FALSE			FALSE		
NA	0.05	14,910	FALSE			FALSE		
0.68	0.05	22,897	FALSE			FALSE		
NA	0.09	9,673	FALSE			FALSE		
0.25	0.05		FALSE			FALSE		February 2011
0.79	0.05	818	FALSE			FALSE		
0.19	0.01	43	FALSE			FALSE		
0.60	0.05	9,371	FALSE			FALSE		
0.74	0.05	29,623	TRUE	July 2014	Yes	TRUE	In October 2(	May 2018
0.18	0.01	7,594	FALSE			FALSE		
0.95	0.05	11	FALSE			FALSE		
NA	0.02		FALSE			FALSE		February 2019
NA	0.05		FALSE			FALSE		February 2019
NA	0.09		FALSE			FALSE		February 2019
NA	0.05		FALSE			FALSE		February 2019
3.43	2.17	24,084	FALSE			TRUE		October 2011
0.00	0.00		FALSE			TRUE		October 2011
4.09	2.59	2,282	FALSE			TRUE		October 2011
0.00	0.00		FALSE			TRUE		October 2011
3.81	2.42	254,826	FALSE			TRUE		October 2011
0.00	0.00		FALSE			TRUE		October 2011
4.27	2.74	19,416	FALSE			TRUE		October 2011
0.00	0.00		FALSE			TRUE		October 2011
3.80	2.42	18,930	FALSE			TRUE		October 2011
0.00	0.00		FALSE			TRUE		October 2011
4.28	2.72	41,108	FALSE			TRUE		October 2011
4.28	2.74	9,129	FALSE			TRUE		October 2011
0.00	0.00		FALSE			TRUE		October 2011
1.01	0.15	201,622	FALSE			FALSE		
1.14	0.74	2,130	FALSE			FALSE		
			FALSE			TRUE	Specialty soci	October 2011
			FALSE			TRUE	Specialty soci	October 2011

			FALSE			TRUE	Specialty soci	October 2011
			FALSE			TRUE	Specialty soci	October 2011
10.90	4.97	2,857	FALSE			FALSE		
		76	FALSE			TRUE	In January 20	September 2019
		1	FALSE			TRUE	In January 20	September 2019
			FALSE			TRUE	Specialty soci	October 2011
			FALSE			TRUE	Specialty soci	October 2011
NA	0.02	########	FALSE			FALSE		
NA	0.01	460,887	FALSE			FALSE		
0.06	0.01	########	FALSE			FALSE		
			FALSE			FALSE		February 2010
			FALSE			FALSE		February 2010
NA	0.05	999,644	TRUE	Jan 2010	Yes	TRUE	The RUC acce	October 2010
0.16	0.02	########	FALSE			FALSE		
NA	0.02	96,453	FALSE			FALSE		
0.11	0.01	########	TRUE	Jan 2010	Yes	TRUE	The RUC acce	October 2010
NA	0.04	213	FALSE			FALSE		
NA	0.02	108,714	FALSE			FALSE		
NA	0.01	12,914	FALSE			FALSE		
0.04	0.01	362,235	FALSE			FALSE		
NA	0.03	284,557	FALSE			TRUE	The ACC and	February 2010
NA	0.01	110,328	FALSE			FALSE		February 2010
NA	0.01	154,751	FALSE			FALSE		February 2010
0.14	0.01	344,162	FALSE			TRUE	The ACC and	Feburary 2010
0.19	0.04	186,123	FALSE			FALSE		
NA	0.09	271,792	FALSE			FALSE		
			FALSE			TRUE	CMS stated t	February 2010
			FALSE			FALSE		February 2010
			FALSE			FALSE		February 2010
			FALSE			TRUE	CMS stated t	February 2010
			FALSE			FALSE		February 2010
			FALSE			TRUE	In February 2	February 2010
			FALSE			TRUE	The ACC and	February 2010
NA	0.04	11,689	FALSE			FALSE		February 2010
NA	0.01	39,075	FALSE			FALSE		February 2010
NA	0.01	54,627	FALSE			FALSE		February 2010
0.18	0.02	104,829	FALSE			FALSE		February 2010
NA	0.03	152,741	FALSE			TRUE	In the NPRM	February 2017
NA	0.05	986,249	FALSE			TRUE	In the NPRM	February 2017
NA	0.05	73,701	FALSE			TRUE	In the NPRM	February 2017
NA	0.05	115,690	FALSE			TRUE	In the NPRM	February 2017
NA	0.05	214,401	FALSE			TRUE	In the NPRM	February 2017
NA	0.05	246,603	FALSE			TRUE	In the NPRM	February 2017
NA	0.03	40,620	FALSE			TRUE	In the NPRM	February 2017
NA	0.02	20,480	FALSE			TRUE	In the NPRM	February 2017
NA	0.03	12,854	FALSE			TRUE	In the NPRM	February 2017
NA	0.02	242,876	FALSE			TRUE	In the NPRM	February 2017

NA	0.05	97,500	FALSE			TRUE	In the NPRM	February 2017
NA	0.03	118,819	FALSE			TRUE	In the NPRM	February 2017
NA	0.02	68,111	FALSE			TRUE	In the NPRM	February 2017
NA	0.03	1,142	FALSE			TRUE	In the NPRM	February 2017
NA	0.02	50,828	FALSE			TRUE	In the NPRM	February 2017
0.24	0.04	########	FALSE			FALSE		
0.30	0.05	618,312	FALSE			FALSE		
NA	0.01	########	FALSE			TRUE	In the NPRM	February 2017
0.21	0.04	436,176	FALSE			FALSE		
0.21	0.04	718,193	FALSE			FALSE		
		790,455	FALSE			TRUE	In October 2(	February 2019
NA	0.07	########	FALSE			FALSE		
NA	0.06	26,672	FALSE			FALSE		
NA	0.03	435,885	FALSE			FALSE		
NA	0.02	365,942	FALSE			FALSE		
NA	0.01	239,405	FALSE			FALSE		
NA	0.00	606,488	FALSE			FALSE		
NA	0.07	95,788	TRUE	Jan 2010	Yes	TRUE	The RUC acce	October 2010
NA	0.09	241,940	FALSE			FALSE		
NA	0.48	44,232	FALSE			FALSE		October 2009
NA	0.84	3,594	FALSE			FALSE		October 2009
NA	1.16	2,368	FALSE			FALSE		October 2009
NA	0.88	127,375	FALSE			FALSE		October 2009
NA	1.03	27,649	FALSE			FALSE		October 2009
NA	1.14	19,829	FALSE			FALSE		October 2009
NA	1.30	3,711	FALSE			FALSE		October 2009
NA	1.07	507,961	FALSE			FALSE		October 2009
NA	1.24	90,436	FALSE			FALSE		October 2009
NA	1.39	89,701	FALSE			FALSE		October 2009
NA	1.51	14,051	FALSE			FALSE		October 2009
1.60	0.82	6,479	FALSE			FALSE		October 2009
0.70	0.15	6,287	FALSE			FALSE		October 2009
NA	0.10	1,054	FALSE			FALSE		October 2009
			FALSE			TRUE	Referred to t	October 2009
0.38	0.17	71,386	FALSE			FALSE		
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009

			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
			FALSE			TRUE	Referred to t	October 2009
NA	0.00	6	FALSE			FALSE		
NA	0.00	14	FALSE			FALSE		
0.39	0.17	167	FALSE			FALSE		October 2009
0.39	0.25	6	FALSE			FALSE		October 2009
0.30	0.14	80	FALSE			FALSE		October 2009
0.30	0.16	388	FALSE			FALSE		October 2009
0.34	0.21	28,640	FALSE			FALSE		October 2009
0.32	0.19	1,334	FALSE			TRUE		October 2009
NA	0.00	69,945	FALSE			FALSE		
NA	0.00	12,600	FALSE			FALSE		
2.27	1.17	80,773	FALSE			FALSE		
NA	0.00	8,849	FALSE			TRUE	The Workgro	October 2011
NA	0.00	29,892	FALSE			FALSE		
NA	0.00	38,626	FALSE			TRUE	In April 2019,	May 2019
NA	0.00	14,210	FALSE			TRUE	33213 - This (	February 2011
			FALSE			TRUE	The Workgro	October 2011
			FALSE			TRUE	The Workgro	October 2011
6.40	3.29	31,821	FALSE			TRUE	The Workgro	October 2011
8.55	4.41	7,750	FALSE			TRUE	The Workgro	October 2011
3.27	1.67	31,147	FALSE			TRUE	The Workgro	October 2011
8.63	4.42	53,327	FALSE			TRUE	In October 2(	October 2020
3.26	1.67	21,959	FALSE			TRUE	The Workgro	October 2011
NA	0.00	63,470	FALSE			FALSE		
NA	0.01	814	FALSE			FALSE		
NA	0.01	14,268	FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
0.29	0.10	97,423	FALSE			FALSE		
NA	0.04	1,742	FALSE			FALSE		September 2016
NA	0.01	########	FALSE			FALSE		September 2016
			TRUE	SS in proce	Yes	TRUE	The Workgro	October 2010
NA	0.08	########	TRUE	Addressed	Yes	TRUE	The Workgro	October 2010
NA	0.08	33,564	FALSE			FALSE		
NA	0.07	104,495	FALSE			TRUE	The Workgro	October 2010
NA	0.06	10,532	FALSE			TRUE	The Workgro	October 2010
NA	0.08	52,137	FALSE			FALSE		
NA	0.09	55,222	FALSE			FALSE		
NA	0.00		FALSE			FALSE		

NA	0.05	694,382	FALSE			TRUE	The Workgro	February 2010
NA	0.07	440,595	FALSE			TRUE	The Workgro	February 2010
NA	0.07	61,266	FALSE			TRUE	The Workgro	February 2010
NA	0.09	661,535	FALSE			FALSE		
NA	0.07	262,918	FALSE			FALSE		
NA	0.13	23,417	FALSE			FALSE		
NA	0.07	47,500	FALSE			TRUE	The Workgro	October 2010
			FALSE			TRUE	In January 20	May 2016
NA	0.07	########	FALSE			FALSE		
NA	0.05	########	FALSE			FALSE		
NA	0.13	218,302	FALSE			FALSE		
NA	0.06	173,269	FALSE			FALSE		
NA	0.12	287,616	FALSE			FALSE		
NA	0.07	66,512	FALSE			FALSE		
			FALSE			FALSE		
NA	0.15		FALSE			FALSE		September 2018
NA	0.08		FALSE			FALSE		September 2018
NA	0.11	132,133	FALSE			FALSE		
NA	0.02	########	FALSE			FALSE		
NA	0.03	47	FALSE			FALSE		
NA	0.01	38	FALSE			FALSE		
0.18	0.02	5,244	FALSE			FALSE		
NA	0.02	########	TRUE	Mar 2014	Yes	FALSE		
NA	0.02	74,436	FALSE			FALSE		
			FALSE			TRUE	The RUC acce	October 2010
		20,825	FALSE			FALSE		
			FALSE			TRUE	The RUC acce	October 2010
			FALSE			TRUE	The RUC acce	October 2010
			FALSE			TRUE	The RUC acce	October 2010
			FALSE			TRUE	The RUC acce	October 2010
		1,310	TRUE	Mar 2014	Yes	TRUE	In January 20	September 2019
NA	0.04	56	FALSE			FALSE		
NA	0.06	9,892	FALSE			FALSE		February 2016
NA	0.03	271,019	FALSE			FALSE		February 2016
			FALSE			TRUE	In January 20	February 2016
NA	0.10	21,378	FALSE			TRUE	In January 20	February 2016
NA	0.01	601,038	TRUE	Mar 2014	Yes	FALSE		
NA	0.01	6,331	FALSE			FALSE		
NA	0.02	5,171	TRUE	Mar 2014	Yes	FALSE		
NA	0.02	324	FALSE			FALSE		
NA	0.02	7,816	FALSE			FALSE		
			FALSE			TRUE	The RUC acce	October 2010
			FALSE			TRUE	The RUC acce	October 2010
NA	0.03	681,512	FALSE			FALSE		February 2011
NA	0.02	348,523	FALSE			FALSE		February 2011
NA	0.02	4,985	FALSE			FALSE		February 2011
NA	0.02	########	FALSE			FALSE		February 2011

		18,981	FALSE			FALSE		
NA	0.01	29,834	FALSE			FALSE		
NA	0.01	16,501	FALSE			FALSE		
NA	0.01	208,171	FALSE			FALSE		
		5,724	TRUE	Mar 2014	Yes	TRUE	In April 2019,	September 2019
NA	0.01	########	FALSE			FALSE		
			FALSE			TRUE	The specialty	February 2012
NA	0.01	136,728	FALSE			FALSE		
			FALSE			TRUE	The specialty	February 2012
0.03	0.01	27,662	FALSE			TRUE	Deleted code	February 2012
0.06	0.01	129,391	FALSE			TRUE	Deleted code	February 2012
0.01	0.01	########	FALSE			FALSE		
NA	0.01	164,524	FALSE			FALSE		
NA	0.01	########	FALSE			FALSE		
NA	0.01	########	FALSE			FALSE		
0.02	0.01	178,622	FALSE			FALSE		
0.02	0.01	20,261	FALSE			FALSE		
0.02	0.01	########	FALSE			FALSE		
NA	0.04	10,730	TRUE	June 2018	yes	TRUE	The RUC recc	June 2017
NA	0.04	76,885	FALSE			TRUE	In May 2014,	October 2015 & Fe
0.28	0.04	248,288	FALSE			TRUE	In October 2(	February 2017
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.00	0.00		FALSE			FALSE		
0.79	0.14		FALSE			FALSE		
1.18	0.20		FALSE			FALSE		
1.32	0.21		FALSE			FALSE		
1.82	0.28		FALSE			FALSE		
1.83	0.28		FALSE			FALSE		
2.22	0.36		FALSE			FALSE		
2.28	0.37		FALSE			FALSE		
2.84	0.45		FALSE			FALSE		
2.61	0.43		FALSE			FALSE		
3.59	0.59		FALSE			FALSE		
NA	0.05	24,715	FALSE			FALSE		October 2009
NA	0.05	422	FALSE			FALSE		October 2009
NA	0.05	232	FALSE			FALSE		

NA	0.13	3,017	FALSE			FALSE		October 2009
NA	0.06	80,376	FALSE			FALSE		October 2009
NA	0.14	3,278	FALSE			FALSE		October 2009
NA	0.15	1,197	FALSE			FALSE		October 2009
NA	0.22	272,131	FALSE			FALSE		October 2009
NA	0.22	333,381	FALSE			FALSE		October 2009
NA	0.09	24,822	FALSE			FALSE		
NA	0.13	31,299	FALSE			FALSE		
NA	0.09	278,212	FALSE			FALSE		
NA	0.09	202,028	FALSE			FALSE		
NA	0.09	26,955	FALSE			FALSE		
		5,020	FALSE			FALSE		
		79,780	FALSE			TRUE	In April 2018,	September 2018
		11,062	FALSE			TRUE	In April 2018,	September 2018
		867	FALSE			TRUE	In April 2018,	September 2018
		605	FALSE			TRUE	In April 2018,	September 2018
NA	0.05	2,418	FALSE			TRUE	The Workgro	February 2011 & O
NA	0.07	44,204	FALSE			TRUE	The Workgro	February 2011 & O
NA	0.07	157	FALSE			TRUE	The Workgro	February 2011 & O
NA	0.11	1,620	FALSE			TRUE	The Workgro	February 2011 & O
NA	0.05	1,113	FALSE			TRUE	Identifed by (	October 2011
NA	0.06	5,630	FALSE			TRUE	Identifed by (	October 2011
NA	0.03	447	FALSE			TRUE	Identifed by (	October 2011
NA	0.03	52,835	FALSE			TRUE	Identifed by (	October 2011
NA	0.01	141,249	FALSE			FALSE	CPT Feb 2011	February 2011 and
NA	0.04	962,501	FALSE			FALSE	CPT Feb 2011	February 2011 and
NA	0.04	14,870	FALSE			FALSE	CPT Feb 2011	February 2011 and
			FALSE			TRUE	Identified as	October 2011& Fel
			FALSE			TRUE	Identified as	October 2011 and
			FALSE			TRUE	The Workgro	February 2011 & O
NA	0.05	6,263	FALSE			TRUE	Deleted 6 ele	February 2012
NA	0.06	58,348	FALSE			TRUE	Deleted 6 ele	February 2012
NA	0.06	134,007	FALSE			TRUE	Deleted 6 ele	February 2012
NA	0.10	157,766	FALSE			TRUE	Deleted 6 ele	February 2012
NA	0.11	175,960	FALSE			TRUE	Deleted 6 ele	February 2012
NA	0.15	78,978	FALSE			TRUE	Deleted 6 ele	February 2012
NA	0.17	81,707	FALSE			TRUE	Deleted 6 ele	February 2012
NA	0.05	54,178	TRUE	Sep 2020	complete	TRUE	For code pair	February 2012
NA	0.06	2,986	TRUE	Dec 2008;	complete	TRUE	For code pair	February 2012
NA	0.05	114,086	TRUE	Sep 2020	complete	FALSE		
NA	0.11	21,055	TRUE	Sep 2020	complete	TRUE	CPT Feb 2012	February 2012
NA	0.06	5,861	FALSE			TRUE	The Workgro	October 2010
NA	0.04	6,658	FALSE			TRUE	The Workgro	October 2010
NA	0.07	325	FALSE			TRUE	The Workgro	October 2010
NA	0.06	1,333	FALSE			TRUE	The Workgro	October 2010
NA	0.02	53,881	FALSE			TRUE	In January 20	May 2016
			FALSE			TRUE	Identified as	October 2011 & Fe

			FALSE			TRUE	Identified as	October 2011 & Fe
NA	0.08	90,204	FALSE			TRUE		October 2010
NA	0.15	41,818	FALSE			TRUE		October 2010
0.31	0.04	25,807	FALSE			TRUE	Deleted 6 ele	February 2012
0.00	0.00		FALSE			TRUE	Deleted 6 ele	February 2012
NA	0.00	22,723	FALSE			TRUE	In January 20	October 2020
		2,415	FALSE			FALSE		
		188,070	FALSE			TRUE	This service v	May 2018
		24,927	FALSE			FALSE		
NA	0.16	623	FALSE			FALSE		
		5,307	TRUE	Dec 2009	Yes	FALSE		
NA	0.13	61,055	FALSE			FALSE		
0.16	0.04	38,689	TRUE	Jul 2016	Yes	TRUE	In January 20	June 2017
0.32	0.06	21,590	FALSE			TRUE	In January 20	February 2015, Jun
0.31	0.09	46,946	FALSE			TRUE	In January 20	May 2014 Februa
			FALSE			TRUE	In January 20	February 2015
			TRUE	Jul 2016	Yes	TRUE	In January 20	June 2017
			TRUE	Jul 2016	Yes	TRUE	In January 20	June 2017
0.36	0.06	8,660	TRUE	February 2	complete	FALSE		June 2017
0.47	0.10	7,130	TRUE	February 2	complete	FALSE		June 2017
			TRUE	Jul 2016	Yes	TRUE	In January 20	June 2017
			TRUE	Jul 2016	Yes	TRUE	In January 20	June 2017
0.35	0.17	570	FALSE			FALSE	CPT codes 95	June 2017
0.17	0.05	843	FALSE			FALSE	CPT codes 95	June 2017
0.31	0.13	1,278	FALSE			FALSE	CPT codes 95	June 2017
0.45	0.10	40,522	TRUE	February 2	complete	FALSE		June 2017
0.40	0.09	58,079	TRUE	February 2	complete	FALSE		June 2017
NA	0.04	1,124	FALSE			TRUE	Identified thr	October 2010
0.32	0.09	8,596	FALSE			TRUE		October 2010
0.28	0.04	112,529	FALSE			FALSE		
			FALSE			TRUE	In the July 20	June 2017
			FALSE			TRUE	In the July 20	June 2017
			FALSE			TRUE	In the July 20	June 2017
NA	0.10	1,273	FALSE			TRUE	In the July 20	June 2017
NA	0.01		FALSE			TRUE	In the July 20	June 2017
			FALSE			TRUE	In the July 20	June 2017
1.01	0.14	1,417	FALSE			TRUE	In the July 20	June 2017
0.35	0.05	132	FALSE			TRUE	In the July 20	June 2017
0.45	0.09	157,733	FALSE			TRUE	In the July 20	June 2017
			FALSE			TRUE	In the July 20	June 2017
			FALSE			TRUE	In the July 20	June 2017
			FALSE			TRUE	In the July 20	June 2017
0.33	0.09	47,794	FALSE			TRUE	In the July 20	June 2017
NA	0.09	4,262	FALSE			TRUE	In the July 20	June 2017
NA	0.01	492,372	FALSE			TRUE	In the July 20	June 2017
0.44	0.11	99,759	FALSE			TRUE	In the July 20	June 2017
0.29	0.09	80,133	FALSE			TRUE	In the July 20	June 2017

0.38	0.10	194,323	FALSE	TRUE	In the July 20	June 2017
0.27	0.06	339,426	FALSE	TRUE	In the July 20	June 2017
0.11	0.04	173,801	FALSE	FALSE		June 2017
0.06	0.02	379,620	FALSE	FALSE		June 2017
NA	0.01	157,925	FALSE	FALSE		June 2017
NA	0.01	353,021	FALSE	FALSE		June 2017
NA	0.01	27,702	FALSE	FALSE		June 2017
		54,601	FALSE	FALSE		September 2018
		10,113	FALSE	FALSE		September 2018
		103,595	FALSE	FALSE		September 2018
		42,795	FALSE	FALSE		September 2018
		8,583	FALSE	TRUE	In October 2(	September 2018
			FALSE	FALSE		September 2018
0.28	0.09		FALSE	FALSE		September 2018
0.19	0.05		FALSE	FALSE		September 2018
0.07	0.02		FALSE	FALSE		September 2018
0.03	0.01		FALSE	FALSE		September 2018
0.01	0.00		FALSE	FALSE		September 2018
0.20	0.05		FALSE	FALSE		September 2018
0.07	0.02		FALSE	FALSE		September 2018
0.58	0.13		FALSE	FALSE		September 2018
0.21	0.04		FALSE	FALSE		September 2018
NA	0.02	248,266	FALSE	TRUE	These service	N/A
NA	0.01	433,535	FALSE	TRUE	These service	N/A
NA	0.04	########	FALSE	FALSE		
NA	0.01	558,744	FALSE	FALSE		
NA	0.02	########	FALSE	FALSE		
NA	0.01	133,379	FALSE	FALSE		
NA	0.01	########	FALSE	TRUE	These service	N/A
NA	0.02	272,442	FALSE	TRUE	These service	N/A
NA	0.01	########	FALSE	TRUE	These service	N/A
NA	0.01	60,948	FALSE	FALSE	Other family	N/A
NA	0.05	758,701	FALSE	TRUE	These service	N/A
NA	0.02	403,494	FALSE	TRUE	These service	N/A
0.28	0.04	12,359	FALSE	FALSE		
0.45	0.05	566	FALSE	FALSE		
NA	0.06	79,884	FALSE	TRUE	These service	N/A
NA	0.04	165,078	FALSE	TRUE	These service	N/A
NA	0.09	########	FALSE	FALSE		
NA	0.02	891,855	FALSE	FALSE		
NA	0.09	30,942	FALSE	FALSE		
NA	0.04	388,626	FALSE	FALSE		
1.00	0.48	60	FALSE	FALSE		
NA	0.01	66,951	FALSE	TRUE	CPT code 965	September 2016
NA	0.02	39,219	FALSE	FALSE		September 2016
NA	0.04	48,673	FALSE	FALSE		September 2016
NA	0.02	386,553	FALSE	FALSE		

0.66	0.05	118,570	TRUE	Sep 2016	Yes	FALSE		
0.74	0.05	29,878	TRUE	Sep 2016	Yes	FALSE		
1.19	0.09	15,528	TRUE	Sep 2016	Yes	FALSE		
			FALSE			TRUE	In Jan 2012, t	February 2015
			FALSE			FALSE		February 2015
			FALSE			FALSE		February 2015
			FALSE			FALSE		February 2015
NA	0.01		FALSE			FALSE		
NA	0.01	560,317	FALSE			FALSE	In February 2010, Physical Medic	
NA	0.01		FALSE			FALSE	In February 2010, Physical Medic	
NA	0.01	864,521	FALSE			FALSE	In February 2010, Physical Medic	
NA	0.01	174,530	FALSE			FALSE	In February 2010, Physical Medic	
NA	0.01	193,036	FALSE			FALSE	In February 2010, Physical Medic	
NA	0.01	849,666	FALSE			FALSE	In February 2010, Physical Medic	
NA	0.01	56,451	FALSE			FALSE	In February 2010, Physical Medic	
NA	0.01	8,235	FALSE			FALSE	In February 2010, Physical Medic	
NA	0.01	########	FALSE			FALSE	In February 2010, Physical Medic	
NA	0.02	########	FALSE			FALSE	In April 2016, the Relativity Asse	
NA	0.02	########	FALSE			FALSE	In April 2016, the Relativity Asse	
NA	0.02	########	FALSE			FALSE	In April 2016, the Relativity Asse	
NA	0.02	########	FALSE			FALSE	In April 2016, the Relativity Asse	
			FALSE			FALSE		September 2016
NA	0.02	########	FALSE			FALSE	In April 2016, the Relativity Asse	
NA	0.01	########	FALSE			FALSE		
NA	0.05	########	FALSE			FALSE		February 2015
NA	0.05	########	FALSE			FALSE		February 2015
NA	0.05	318,604	FALSE			FALSE		February 2015
NA	0.04	585,829	FALSE			FALSE		February 2015
NA	0.05	146,443	FALSE			FALSE		February 2015
NA	0.05	101,883	FALSE			FALSE		February 2015
NA	0.05	22,637	FALSE			FALSE		February 2015
NA	0.04	33,480	FALSE			FALSE		February 2015
NA	0.02	########	FALSE			FALSE	In April 2016, the Relativity Asse	
			FALSE			TRUE	In April 2016	September 2016
NA	0.02	21,250	FALSE			FALSE	In April 2016 the Relativity Asses	
NA	0.02	########	TRUE	Article no	Yes	FALSE	In April 2016 the Relativity Asses	
NA	0.02	23,275	FALSE			FALSE	In April 2016 the Relativity Asses	
NA	0.02	61,278	FALSE			FALSE	In April 2016, the Relativity Asse	
0.22	0.05	897,614	FALSE			TRUE	In January 2018, the RUC recomr	
0.18	0.05	135,670	FALSE			TRUE	In January 2018, the RUC recomr	
0.00	0.00		FALSE			FALSE		
0.16	0.02	51,268	FALSE			FALSE		
0.18	0.02	15,612	FALSE			FALSE		
0.17	0.09	5,825	FALSE			FALSE		
0.19	0.09	1,172	FALSE			FALSE		
0.12	0.01	12,331	FALSE			FALSE		
NA	0.02	2,693	FALSE			FALSE		

NA	0.02	57,907	FALSE			TRUE	In April 2016	September 2016
NA	0.02	2,698	FALSE			TRUE	In April 2016	September 2016
			FALSE			TRUE	In April 2016	September 2016
NA	0.02	38,754	FALSE			FALSE		
0.40	0.02	224,711	FALSE			FALSE		
0.34	0.02	211,418	FALSE			FALSE		
0.20	0.04	65,014	FALSE			FALSE		
0.28	0.04	109,622	FALSE			FALSE		
0.35	0.05	99,716	FALSE			FALSE		
0.44	0.05	99,045	FALSE			FALSE		
0.53	0.09	76,576	FALSE			FALSE		
0.17	0.01	########	FALSE			FALSE		
0.26	0.01	########	FALSE			FALSE		
0.36	0.02	948,986	FALSE			FALSE		
0.18	0.04		FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
			FALSE			FALSE		
0.18	0.05	11	FALSE			FALSE		
0.09	0.02	########	FALSE			FALSE		
0.32	0.21	30	FALSE			FALSE		
0.41	0.16	7,955	FALSE			FALSE		
NA	0.01		FALSE			TRUE	CMS request	May 2014
NA	0.01		FALSE			TRUE		May 2014
0.78	0.26	386,280	FALSE			FALSE		
0.11	0.05	67,730	FALSE			FALSE		
0.21	0.10	352,496	FALSE			FALSE		
0.33	0.16	########	FALSE			FALSE		
0.54	0.27	########	FALSE			FALSE		
0.75	0.43	########	FALSE			FALSE		
0.95	0.15		FALSE			TRUE	In October 2(	February 2021
0.47	0.06		FALSE			TRUE	In October 2(	February 2021
			FALSE			FALSE		September 2016
			FALSE			FALSE		September 2016
0.67	0.14		FALSE			FALSE		
0.67	0.14		FALSE			FALSE		
0.82	0.09	48,091	TRUE	Oct 2018	yes	FALSE		
0.68	0.13	16,445	FALSE			FALSE		
0.76	0.13	14,660	FALSE			FALSE		
0.30	0.05	27,335	FALSE			FALSE		
0.65	0.10	########	TRUE	Dec 2014	Yes	FALSE		
0.63	0.09	60,204	TRUE	Dec 2014	Yes	FALSE		
0.29	0.06	929,962	FALSE			FALSE		
0.07	0.01	30,358	FALSE			FALSE		
0.67	0.11	2,724	FALSE			FALSE		October 2013

1.73	0.41	262,478	FALSE			FALSE	
NA	0.05	172,612	FALSE			FALSE	
NA	0.01	111,248	FALSE			FALSE	
1.73	0.42	215,409	FALSE			FALSE	
0.36	0.01	47,978	FALSE			FALSE	
0.04	0.01	########	FALSE			FALSE	
0.36	0.01	3,666	FALSE			FALSE	
NA	0.04	95,502	FALSE			FALSE	
0.08	0.05	44,921	FALSE			FALSE	
NA	0.04	806,300	FALSE			FALSE	The Workgroup asked CMS why
NA	0.05	########	FALSE			FALSE	The Workgroup asked CMS why
NA	0.11	386,948	FALSE			FALSE	The Workgroup asked CMS why
NA	0.11	26,148	FALSE			FALSE	
			FALSE			TRUE	In the NPRM October 2015
			FALSE			TRUE	In the NPRM October 2015
			FALSE			TRUE	In the NPRM October 2015
NA	0.01	40,969	FALSE			FALSE	
NA	0.01	49,322	FALSE			FALSE	
NA	0.04	23,312	FALSE			TRUE	In October 2(September 2016
NA	0.01	########	FALSE			TRUE	In October 2(September 2016
NA	0.01	185,069	FALSE			TRUE	In October 2(September 2016
0.27	0.09	166,164	FALSE			FALSE	
0.34	0.02	81,177	FALSE			FALSE	
NA	0.04	783,467	FALSE			FALSE	
NA	0.01	########	FALSE			FALSE	In April 2016, the Relativity Asse
0.20	0.04	50,164	FALSE			FALSE	
		260,400	FALSE			TRUE	In October 2(May 2019
			FALSE			FALSE	
		38,289	FALSE			TRUE	In October 2(September 2018
			TRUE	Jan 2017	yes	TRUE	When Medic May 2015
0.25	0.05	51,068	FALSE			TRUE	In October 2(Time Uncertain
NA	0.00	112,455	FALSE			FALSE	
1.14	0.15	526,509	FALSE			FALSE	
NA	0.02	129,413	FALSE			FALSE	
0.57	0.10		FALSE			FALSE	
0.82	0.14		FALSE			FALSE	
NA	0.09	133,021	FALSE			FALSE	
1.43	0.20		FALSE			FALSE	
1.43	0.20		FALSE			FALSE	
			FALSE			FALSE	
NA	0.15	########	FALSE			FALSE	The Workgroup asked CMS why
NA	0.13	########	FALSE			FALSE	The Workgroup asked CMS why
0.08	0.01	893,133	FALSE			FALSE	
0.08	0.01	########	FALSE			FALSE	
0.20	0.04	253,992	FALSE			FALSE	
0.20	0.04	336,973	FALSE			FALSE	
NA	0.05	128,942	FALSE			FALSE	

0.30	0.05	402,739	FALSE	FALSE	
			FALSE	TRUE	In January 20 May 2013
			FALSE	TRUE	In January 20 May 2013
0.04	0.02		FALSE	FALSE	
0.37	0.05		FALSE	FALSE	
NA	0.03		FALSE	TRUE	The RUC iden September 2021
NA	0.02	########	FALSE	FALSE	
NA	0.02		FALSE	FALSE	
NA	0.02		FALSE	FALSE	
NA	0.02	22,014	FALSE	FALSE	
NA	0.04		FALSE	FALSE	
0.00	0.00		FALSE	FALSE	
			FALSE	FALSE	
0.36	0.01	1,599	FALSE	FALSE	
0.14	0.04	533,729	FALSE	FALSE	

CPT Tab	CPT Ed Panel Status Complete?	Complete	Result
		TRUE	Remove from Screen
		TRUE	Increase
		TRUE	Remove from Screen
12	yes	TRUE	Maintain
12	yes	TRUE	Increase
12	yes	TRUE	Deleted from CPT
12	yes	TRUE	Deleted from CPT
12	yes	TRUE	Decrease
12	yes	TRUE	Decrease
12	yes	TRUE	Maintain
		TRUE	Remove from screen
		FALSE	
37	complete	TRUE	Deleted from CPT
		TRUE	Remove from Screen
15	complete	TRUE	Deleted from CPT
15	complete	TRUE	Deleted from CPT
15	complete	TRUE	Decrease
15	complete	TRUE	Decrease
15	complete	TRUE	Decrease
15	complete	TRUE	Decrease
15	complete	TRUE	Increase
15	complete	TRUE	Increase
		TRUE	Maintain
37	complete	TRUE	Deleted from CPT
		FALSE	
		FALSE	
46		FALSE	
46		FALSE	
46		FALSE	
		TRUE	Maintain
		TRUE	Maintain
		FALSE	
37	complete	TRUE	Contractor Price
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Contractor Price
		TRUE	Contractor Price
06	yes	TRUE	Decrease
06	yes	TRUE	Deleted from CPT

06	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
15	Code Deleted	TRUE	Deleted from CPT
15	Code Deleted	TRUE	Deleted from CPT
15	Complete	TRUE	Increase
15	Complete	TRUE	Decrease
15	Complete	TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Increase
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
65	yes	TRUE	Deleted from CPT
65	yes	TRUE	Deleted from CPT
65	yes	TRUE	Decrease
65	yes	TRUE	Decrease
65	yes	TRUE	Decrease
65	yes	TRUE	Decrease
65	yes	TRUE	Decrease
65	yes	TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
09	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
10	Yes	TRUE	Decrease

10	Yes	TRUE	Decrease
10	Yes	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Remove from Screen
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
9	Complete	TRUE	Decrease
9	Complete	TRUE	Decrease
9	Complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
05	Deleted from C	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease

		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
09	Code Deleted	TRUE	Deleted from CPT
09		TRUE	Decrease
09		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Remove from Screen
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
07	Complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	PE Only
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
07	Complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
07	Complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
07	Complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
07	Complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain

		TRUE	Maintain
		TRUE	Decrease
15	yes	TRUE	Not Part of RAW
15	yes	TRUE	Deleted from CPT
		TRUE	Decrease
15	yes	TRUE	Increase
15	yes	TRUE	Maintain
15	yes	TRUE	Maintain
11 & 07	Complete	TRUE	Maintain
		FALSE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Remove from Screen
		TRUE	Remove from screen
17	yes	FALSE	
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Deleted from CPT

08	Complete	TRUE	Deleted from CPT
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Decrease
08	Complete	TRUE	Deleted from CPT
08	Complete	TRUE	Deleted from CPT
08	Complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	PE Only
		TRUE	Decrease
20	Complete	TRUE	Decrease
15	Code Deleted	TRUE	Deleted from CPT
06	complete	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
	revised	TRUE	Decrease
		TRUE	PE Only
		TRUE	Remove from Screen
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
06	Complete	TRUE	Maintain
06		TRUE	Decrease
06	Complete	TRUE	Maintain
06		TRUE	Decrease
06	Complete	TRUE	Maintain
06		TRUE	Decrease
		TRUE	Remove from Screen
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease

12	Yes	TRUE	Deleted from CPT
06	New code stru	TRUE	Increase
		TRUE	Decrease
		TRUE	Deleted from CPT
06	New code stru	TRUE	Decrease
15	Complete	TRUE	Deleted from CPT
7	Complete	TRUE	Deleted from CPT
07	Complete	TRUE	Deleted from CPT
07	Complete	TRUE	Decrease
07	Complete	TRUE	Decrease
07	Complete	TRUE	Decrease
07	Complete	TRUE	PE Only
07	Complete	TRUE	Remove from screen
06	New code stru	TRUE	Decrease
		TRUE	Maintain
13	Complete	TRUE	Deleted from CPT
		FALSE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
		TRUE	Remove from Screen
21		TRUE	Decrease
21		TRUE	Maintain
21	Complete	TRUE	Maintain
20	yes	FALSE	
21		TRUE	Maintain
16	Complete	TRUE	Maintain
		TRUE	Decrease
16	Complete	TRUE	Maintain
		TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
		TRUE	Remove from Screen
10	Complete Intrc	TRUE	Maintain
14	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Increase
		TRUE	Decrease

06	New code stru	TRUE	Increase
06	New code stru	TRUE	Decrease
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Remove from Screen
		TRUE	PE Only
		TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
06	New code stru	TRUE	Increase

		TRUE	Maintain
76	Code Revised.	TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
	Code Deleted	TRUE	Deleted from CPT
	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
EC-O	complete	TRUE	Maintain
09	yes	TRUE	Deleted from CPT
		FALSE	Increase
		TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
06	New code stru	TRUE	Increase
06	New code stru	TRUE	Decrease
07	Complete	TRUE	Maintain
07	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only

		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	PE Only
		TRUE	Increase
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Increase
19	Complete	TRUE	Decrease
19	Complete	TRUE	Deleted from CPT
19	Complete	TRUE	Decrease
19	Complete	TRUE	Decrease
19	Complete	TRUE	Deleted from CPT
19	Complete	TRUE	Deleted from CPT
19	Complete	TRUE	Decrease
19	Complete	TRUE	Decrease
19	Complete	TRUE	Decrease
19	Complete	TRUE	Decrease
19	Complete	TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
10	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
22	yes	TRUE	Deleted from CPT
22	yes	TRUE	Deleted from CPT
		FALSE	
08	Code Deleted	TRUE	Deleted from CPT
		TRUE	PE Only

14	yes	TRUE	Decrease
14	yes	TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Decrease
		TRUE	PE Only
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
		TRUE	Maintain
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
24	yes	TRUE	Decrease
		TRUE	Increase
13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
13	Complete	TRUE	Decrease
13	Deleted from C	TRUE	Deleted from CPT

13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
13	Deleted from C	TRUE	Deleted from CPT
13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	PE Only
10	Complete	TRUE	Deleted from CPT
10	Complete	TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
10	Complete	TRUE	Maintain
10	Complete	TRUE	Maintain
10	Complete	TRUE	Maintain
10	Complete	TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
14	Complete	TRUE	Decrease
14	Complete	TRUE	Increase
10	Complete	TRUE	Decrease
10	Complete	TRUE	Decrease
10	Complete	TRUE	Decrease
06	Complete	TRUE	Deleted from CPT
11	complete	TRUE	Deleted from CPT
		TRUE	Increase
10	Complete	TRUE	Deleted from CPT
10	Complete	TRUE	Deleted from CPT
10	Complete	TRUE	Deleted from CPT
		TRUE	Remove from screen
		TRUE	Remove from Screen
		TRUE	Remove from Screen
		TRUE	Remove from Screen
09	Complete	TRUE	Increase
10	Complete	TRUE	Decrease
10	Complete	TRUE	Decrease
10	Complete	TRUE	Decrease
10	Complete	TRUE	Decrease
		TRUE	Remove from Screen
14	Complete	TRUE	Deleted from CPT
14	Complete	TRUE	Deleted from CPT
14	Complete	TRUE	Deleted from CPT
14	Complete	TRUE	Increase
14	Complete	TRUE	Increase

14	Complete	TRUE	Increase
14	Complete	TRUE	Increase
EC	Yes	TRUE	Decrease
EC	Yes	TRUE	Decrease
13	Complete	TRUE	Maintain
13	Complete	TRUE	Maintain
13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13	Complete	TRUE	Maintain
13	Complete	TRUE	Decrease
13	Complete	TRUE	Maintain
13	Complete	TRUE	Maintain
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
12	yes	TRUE	Decrease
12	yes	TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
16	yes	TRUE	Maintain
16	yes	TRUE	Maintain
16	yes	TRUE	Maintain
		TRUE	Remove from Screen
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Deleted from CPT

23	Complete	TRUE	Deleted from CPT
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
23	Complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Deleted from CPT
	yes	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
27	yes	TRUE	Decrease
		TRUE	Decrease
27	yes	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
07		TRUE	Deleted from CPT
07		TRUE	Deleted from CPT

		TRUE	Deleted from CPT
07		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
	Deleted from C	TRUE	Deleted from CPT
˙ referral	Complete	TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
	Deleted from C	TRUE	Deleted from CPT
	Deleted from C	TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
07	Deleted- New (	TRUE	Deleted from CPT
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Deleted from CPT
17	Complete	TRUE	Deleted from CPT
17	Complete	TRUE	Deleted from CPT
they could	Complete	TRUE	Maintain
15		TRUE	Remove from screen
		TRUE	Remove from Screen
31	Code Deleted	TRUE	Deleted from CPT
27	Complete	TRUE	Deleted from CPT
27	Complete	TRUE	Deleted from CPT
ɛ specialtie	Complete	TRUE	Decrease
ɛ specialtie	Complete	TRUE	Maintain
ˊ societies i	Complete	TRUE	Maintain
		TRUE	Maintain
12	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
07 & 06	New code stru	TRUE	Decrease
		TRUE	Maintain
		TRUE	Increase
07	New code stru	TRUE	Remove from Screen
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease

		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	PE Only
30	yes	TRUE	Increase
30	yes	TRUE	Increase
30	yes	TRUE	Increase
30	yes	TRUE	Increase
30	yes	TRUE	Deleted from CPT
30	yes	TRUE	Increase
30	yes	TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
16	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
23	Complete	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Decrease
18	Code Deleted	TRUE	Deleted from CPT
27	Complete	TRUE	Deleted from CPT
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
		TRUE	PE Only
15		TRUE	Decrease
15		TRUE	Decrease
15		TRUE	Decrease
18	Complete	TRUE	Deleted from CPT
	Complete	TRUE	Deleted from CPT
09	Complete	TRUE	Deleted from CPT

10	Complete	TRUE	Deleted from CPT
10	Complete	TRUE	Deleted from CPT
10	Complete	TRUE	Deleted from CPT
10	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Deleted from CPT
09	Complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
		FALSE	Decrease
10	Complete	TRUE	Decrease
10	Complete	TRUE	Decrease
10	Complete	TRUE	Decrease
10	Complete	TRUE	Decrease
09		TRUE	Decrease
09		TRUE	Decrease
09		TRUE	Decrease
09		TRUE	Decrease
24	Complete	TRUE	Decrease
24	Complete	TRUE	Decrease
24	Complete	TRUE	Decrease
24	Complete	TRUE	Decrease
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
		TRUE	PE Only
15		TRUE	Increase
15	Code Deleted	TRUE	Deleted from CPT
19	Complete	TRUE	Maintain
		TRUE	Increase

		TRUE	Decrease
		TRUE	Decrease
		TRUE	PE Only
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
14	Complete	TRUE	Deleted from CPT
14	Complete	TRUE	Decrease
14	Complete	TRUE	Increase
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain

		TRUE	Maintain
		TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
14	Complete	TRUE	Decrease
11	Complete	TRUE	Deleted from CPT
14	Complete	TRUE	Decrease
14	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
12	Complete	TRUE	Decrease
by CMS through the MPC I		TRUE	Maintain
12	Complete	TRUE	Increase
		TRUE	Maintain
12	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
12	Complete	TRUE	Decrease
14	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Deleted from CPT
		TRUE	Decrease
14	Complete	TRUE	Deleted from CPT
12	Complete	TRUE	Decrease
13	Complete	TRUE	Maintain
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Maintain
13		TRUE	Decrease
13		TRUE	Decrease
14	Complete	TRUE	Decrease
13		TRUE	Deleted from CPT
13		TRUE	Deleted from CPT
13		TRUE	Deleted from CPT
14	Complete	TRUE	Decrease
13		TRUE	Deleted from CPT

13		TRUE	Deleted from CPT
13		TRUE	Maintain
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
14	Complete	TRUE	Deleted from CPT
14	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Remove from screen
		TRUE	Remove from Screen
		TRUE	Remove from Screen
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Maintain
	Complete	TRUE	Deleted from CPT
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
17	Complete	TRUE	Maintain
17	Complete	TRUE	Decrease
17	Complete	TRUE	Maintain
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Deleted from CPT
17	Complete	TRUE	Decrease
17	Complete	TRUE	Deleted from CPT
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
06	Complete	TRUE	Deleted from CPT
		TRUE	Remove from Screen
18	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
	Complete	TRUE	Decrease

	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Deleted from CPT
	Complete	TRUE	Decrease
16	Complete	TRUE	Increase
16	Complete	TRUE	Decrease
	Complete	TRUE	Deleted from CPT
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
32	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Decrease
18	Complete	TRUE	Maintain
18	Complete	TRUE	Decrease
18	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	PE Only
		TRUE	Increase
06	Complete	TRUE	Deleted from CPT
		TRUE	Increase
16	Complete	TRUE	Deleted from CPT
		TRUE	PE Only
17	CPT Editorial P	TRUE	Decrease
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT

16		TRUE	Deleted from CPT
16		TRUE	Deleted from CPT
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16		TRUE	Increase
16	Complete	TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
		TRUE	PE Only
06	Complete	TRUE	Deleted from CPT
06	Complete	TRUE	Deleted from CPT
06	Complete	TRUE	Deleted from CPT
06	Complete	TRUE	Deleted from CPT
09	Complete	TRUE	Deleted from CPT
09		TRUE	Deleted from CPT
09		TRUE	Decrease
09		TRUE	Decrease
09		TRUE	Increase
06	Complete	TRUE	Decrease
06	Complete	TRUE	Decrease
06	Complete	TRUE	Decrease
30		TRUE	Decrease
30	Deleted	TRUE	Deleted from CPT
30	Revised	TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
18		FALSE	
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain

06	Complete	TRUE	Deleted from CPT
		FALSE	
		FALSE	
		TRUE	PE Only
		TRUE	Maintain
18	Complete	TRUE	Maintain
18	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Deleted from CPT
19	complete	TRUE	Deleted from CPT
18	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Increase
18	Complete	TRUE	Increase
18	Complete	TRUE	Maintain
		TRUE	Maintain
18	Complete	TRUE	Increase
18	Complete	TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Remove from Screen
		TRUE	Remove from Screen
		TRUE	Maintain
		TRUE	Maintain
18	Complete	TRUE	Increase
18	Complete	TRUE	Increase
18	Complete	TRUE	Increase
18	Complete	TRUE	Increase
18	Complete	TRUE	Increase
18	Complete	TRUE	Increase
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
24	Complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
24	Code Deleted	TRUE	Deleted from CPT
34	Complete	TRUE	Decrease
34	Complete	TRUE	Maintain
24	Code Deleted	TRUE	Deleted from CPT
24	Code Revised	TRUE	Maintain

		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Remove from Screen
15	Complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
15	Complete	TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Remove from Screen
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
ıat it will su	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Not Part of RAW
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
33	Complete	TRUE	Decrease

33		TRUE	Decrease
		TRUE	Maintain
35	yes	TRUE	Decrease
35	yes	TRUE	Decrease
35	yes	TRUE	Decrease
35	yes	TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
06	Complete	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Remove from Screen
		TRUE	Remove from Screen
		TRUE	Remove from Screen
21	Complete	TRUE	Remove from screen
34		TRUE	Decrease

34		TRUE	Decrease
34		TRUE	Decrease
		TRUE	Deleted from CPT
34	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
35	Complete	TRUE	Decrease
		TRUE	Maintain
24	Complete	TRUE	Increase
24	Complete	TRUE	Increase
		TRUE	PE Only
21	Complete	TRUE	Maintain
		TRUE	PE Only
		TRUE	Maintain
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
15	Complete	TRUE	Deleted from CPT
15	Complete	TRUE	Deleted from CPT
15	Complete	TRUE	Deleted from CPT
15	Complete	TRUE	Deleted from CPT
15	Complete	TRUE	Decrease
15	Complete	TRUE	Decrease
15	Complete	TRUE	Decrease
15	Complete	TRUE	Decrease
15	Complete	TRUE	Decrease
15	Complete	TRUE	Decrease
15	Complete	TRUE	Decrease
15	Complete	TRUE	Decrease
24	Complete	TRUE	Increase
24	Complete	TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
49	Complete	TRUE	Maintain
49	Complete	TRUE	Decrease
49	Complete	TRUE	Decrease
49	Complete	TRUE	Decrease
		FALSE	Maintain
		TRUE	Maintain

		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
	Complete	TRUE	Maintain
21	Complete	TRUE	Maintain
21		TRUE	Maintain
20	yes	FALSE	
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
19	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		FALSE	Decrease
		TRUE	Decrease
		TRUE	Maintain
21	Complete	TRUE	Deleted from CPT
		FALSE	Maintain
		FALSE	Decrease
		FALSE	
		TRUE	Decrease
		TRUE	Maintain
		FALSE	Decrease
		FALSE	Maintain
		FALSE	Decrease
31	Complete	TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Not Part of RAW
		TRUE	Not Part of RAW
		TRUE	Not Part of RAW
28	Code Deleted	TRUE	Deleted from CPT
28	Code Deleted	TRUE	Deleted from CPT
28	Code Deleted	TRUE	Deleted from CPT
28	Code Deleted	TRUE	Deleted from CPT
19	CPT Editorial P	TRUE	Increase
19	CPT Editorial P	TRUE	Decrease
19	CPT Editorial P	TRUE	Decrease
19	CPT Editorial P	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease

		TRUE	Decrease
		TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
12	yes	TRUE	Deleted from CPT
36	yes	TRUE	Increase
36	yes	TRUE	Increase
36	yes	TRUE	Decrease
36	yes	TRUE	Deleted from CPT
		TRUE	Maintain
35		TRUE	Decrease
35	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
s identified	Code incorrect	TRUE	Remove from screen
		TRUE	Maintain
EC & 7	Code Deleted	TRUE	Deleted from CPT
EC & 7	Code Deleted	TRUE	Deleted from CPT
EC & 7	Code Deleted	TRUE	Deleted from CPT
EC & 7	Code Deleted	TRUE	Deleted from CPT
20	complete	TRUE	Decrease
20	complete	TRUE	Maintain
20	complete	TRUE	Decrease
20	complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
32	Editorial Chang	TRUE	Remove from Screen
		TRUE	Decrease
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
19	Complete	TRUE	Decrease
19	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
36	complete	TRUE	Decrease
		TRUE	Decrease
24	Complete	TRUE	Decrease
24	Complete	TRUE	Decrease
		TRUE	Maintain
24	Complete	TRUE	Decrease
24	Complete	TRUE	Increase
26	Yes	TRUE	Decrease
33	Revised	TRUE	Decrease

		TRUE	Maintain
		TRUE	Decrease
		TRUE	Contractor Price
26	Yes	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
37	complete	TRUE	Maintain
37	complete	TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
23		TRUE	Decrease
23		TRUE	Decrease
23		TRUE	Maintain
23	Complete	TRUE	Deleted from CPT
23	Complete	TRUE	Decrease
	complete	TRUE	Decrease
	Complete	TRUE	Decrease
/ith reques	Complete	TRUE	Decrease
/ith reques	Complete	TRUE	Decrease
		TRUE	Maintain
		TRUE	Remove from Screen
24	Complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease

		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
18	Complete	TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
19	Complete	TRUE	Decrease
41	Complete	TRUE	Deleted from CPT
41	Complete	TRUE	Deleted from CPT
41	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
34	Revised	TRUE	Decrease
25	Code Deleted	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Increase
		TRUE	Maintain
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain

		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Deleted from CPT
20	Complete	TRUE	Decrease
20	Complete	TRUE	Decrease
20	Complete	TRUE	Decrease
20	Complete	TRUE	Decrease
13	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Decrease
		TRUE	Increase
17	Complete	TRUE	Maintain
17	Complete	TRUE	Decrease
17	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
18	Complete	TRUE	Maintain
18	Complete	TRUE	Decrease
18	Complete	TRUE	Decrease
18	Complete	TRUE	Maintain

		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
27	Complete	TRUE	Maintain
		TRUE	Increase
19	Complete	TRUE	Maintain
37	Complete	TRUE	Maintain
37	Complete	TRUE	Maintain
37	Complete	TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
21	Complete	TRUE	Maintain
21	Complete	TRUE	Maintain
21	Complete	TRUE	Maintain
21	Complete	TRUE	Maintain
40	complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain

		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Remove from Screen
		TRUE	Remove from Screen
		TRUE	Remove from Screen
		TRUE	Maintain
		TRUE	Maintain
27	Complete	TRUE	Deleted from CPT
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Deleted from CPT
27	Complete	TRUE	Deleted from CPT
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
27	Complete	TRUE	Deleted from CPT
76	Code Deleted	TRUE	Deleted from CPT
27	Complete	TRUE	Deleted from CPT
27	Complete	TRUE	Decrease
27	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		FALSE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Remove from Screen
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
21	Complete	TRUE	Deleted from CPT
21	Complete	TRUE	Deleted from CPT
21	Complete	TRUE	Decrease

21	Complete	TRUE	Decrease
21	Complete	TRUE	Deleted from CPT
21	Complete	TRUE	Decrease
21	Complete	TRUE	Maintain
37	Complete	TRUE	Maintain
37	Complete	TRUE	Maintain
37	Complete	TRUE	Maintain
		TRUE	Decrease
19	Complete	TRUE	Decrease
37		TRUE	Decrease
37		TRUE	Decrease
37		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Increase
		TRUE	Maintain
27	Yes	TRUE	Increase
27	Yes	TRUE	Deleted from CPT
27	Yes	TRUE	Deleted from CPT
27	Yes	TRUE	Increase
27	Yes	TRUE	Deleted from CPT
EC-T Issue	complete	TRUE	Increase
27	Yes	TRUE	Deleted from CPT
27	Yes	TRUE	Increase
27	Yes	TRUE	Increase
27	Yes	TRUE	Deleted from CPT
27	Yes	TRUE	Increase
27	Yes	TRUE	Increase
		TRUE	Decrease
		TRUE	Maintain
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16		TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Increase
27	yes	TRUE	Increase
18	Complete	TRUE	Deleted from CPT
18	Complete	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Remove from screen
		TRUE	Remove from screen

		TRUE	Remove from screen
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
12	Complete	TRUE	Deleted from CPT
12	Complete	TRUE	Deleted from CPT
12	Complete	TRUE	Deleted from CPT
		FALSE	Increase
		TRUE	Increase
06	Code Deleted	TRUE	Deleted from CPT
06	Code Deleted	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Increase
31	Deleted	TRUE	Deleted from CPT
24	Complete	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Increase
		TRUE	PE Only
		TRUE	PE Only
t 2018		TRUE	Maintain
21 & 14	Complete	TRUE	Deleted from CPT
21	Complete	TRUE	Contractor Price
14	Code Deleted	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
10	Code Deleted	TRUE	Deleted from CPT
	Code Deleted	TRUE	Deleted from CPT
24	Complete	TRUE	Deleted from CPT
24	Complete	TRUE	Deleted from CPT
24	Complete	TRUE	Deleted from CPT
24	Complete	TRUE	Deleted from CPT
24	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Deleted from CPT
t 2018		TRUE	Increase
07	Deleted-new c	TRUE	Deleted from CPT
07	Deleted-new c	TRUE	Deleted from CPT
07	Category III	TRUE	Deleted from CPT
07	Category III	TRUE	Deleted from CPT
07	Category III	TRUE	Deleted from CPT
		TRUE	Increase
27	complete	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	PE Only

		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		FALSE	
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
28	yes	TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
26	Complete	TRUE	Increase
26	Complete	TRUE	Increase
26	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
23	Complete	TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Remove from screen
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
37	Deleted	TRUE	Deleted from CPT
13	yes	FALSE	
13	yes	FALSE	Decrease
14	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		FALSE	
		TRUE	Maintain
		FALSE	Maintain
		TRUE	Increase
28	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
9	Complete	TRUE	Deleted from CPT
		FALSE	
	Complete	TRUE	Maintain
	Complete	TRUE	Maintain
	Complete	TRUE	Maintain
		TRUE	PE Only
11	complete	TRUE	Increase
·ding the radiation oncolog		FALSE	

08	Complete	TRUE	Deleted from CPT
08	Complete	TRUE	Deleted from CPT
14		TRUE	Decrease
14		TRUE	Decrease
14		TRUE	Increase
14		TRUE	Increase
38	Complete	TRUE	Deleted from CPT
38	Complete	TRUE	Deleted from CPT
38	Complete	TRUE	Deleted from CPT
38	Complete	TRUE	Deleted from CPT
38	Complete	TRUE	Deleted from CPT
14	yes	TRUE	Deleted from CPT
14	yes	TRUE	Deleted from CPT
38	Complete	TRUE	Increase
38	Complete	TRUE	Increase
38	Complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Maintain
		TRUE	Increase
22	Complete	TRUE	Deleted from CPT
	Complete	TRUE	Maintain
		TRUE	Decrease
	Complete	TRUE	Deleted from CPT
22	Complete	TRUE	Deleted from CPT
	Complete	TRUE	Decrease
	Complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
22	Complete	TRUE	Maintain
22	Complete	TRUE	Maintain
22	Complete	TRUE	Maintain
22	Complete	TRUE	Decrease
22, 28/29	Complete	TRUE	Decrease
44, 28/29	complete	TRUE	Maintain
		TRUE	Maintain
44	Complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
44	Complete	TRUE	Deleted from CPT
44	Complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
44	Complete	TRUE	Decrease
44	Complete	TRUE	Deleted from CPT

44	Complete	TRUE	Deleted from CPT
44	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
28	Complete	TRUE	PE Only
28	Complete	TRUE	PE Only
28	Complete	TRUE	Decrease
08	Withdrawn at (	TRUE	PE Only
28 & 45	Complete	TRUE	PE Only
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	PE Only
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	PE Only
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Deleted from CPT
28	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
21	Complete	TRUE	Decrease
		TRUE	Remove from screen
		TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
28/29	Complete	TRUE	Decrease
28/29	Complete	TRUE	Decrease
28/29	Complete	TRUE	Decrease
28/29	Complete	TRUE	Decrease
28/29	Complete	TRUE	Decrease
35	Complete	TRUE	Deleted from CPT
35	Complete	TRUE	Deleted from CPT
35	Complete	TRUE	Decrease
36	Code Deleted	TRUE	Deleted from CPT

36	Code Deleted	TRUE	Deleted from CPT
36	Code Deleted	TRUE	Deleted from CPT
28/29	Complete	TRUE	Deleted from CPT
28/29	Complete	TRUE	Deleted from CPT
28/29	Complete	TRUE	Deleted from CPT
35	Complete	TRUE	Decrease
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Deleted from CPT
13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
13	Complete	TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
21	Complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Not Part of RAW
		TRUE	Not Part of RAW
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
23		TRUE	Deleted from CPT
23		TRUE	Deleted from CPT
23		TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
		TRUE	Maintain
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
		TRUE	Increase

28	Yes	TRUE	Increase
23	Complete	TRUE	Decrease
23	Code Deleted	TRUE	Maintain
23	Complete	TRUE	Decrease
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
23	Code Deleted	TRUE	Deleted from CPT
23		TRUE	Decrease
23	Complete	TRUE	Decrease
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
50	complete	TRUE	Deleted from CPT
50	complete	TRUE	Deleted from CPT
50	complete	TRUE	Decrease
50	complete	TRUE	Decrease
50	complete	TRUE	Decrease
50	complete	TRUE	Decrease
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
30	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
uested that this service be		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain

		TRUE	Maintain
		TRUE	Maintain
12	Complete	TRUE	Maintain
12	Complete	TRUE	Maintain
12	Complete	TRUE	Maintain
12	Complete	TRUE	Deleted from CPT
12	Complete	TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
	Complete	TRUE	Decrease
		TRUE	Deleted from CPT
		TRUE	Decrease
45	Complete	TRUE	Decrease
45	Complete	TRUE	Deleted from CPT
		TRUE	PE Only
	Complete	TRUE	Deleted from CPT
45	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
	Complete	TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
55	Complete	FALSE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Deleted from CPT
93	Complete	TRUE	Deleted from CPT
93	Complete	TRUE	Deleted from CPT

93	Complete	TRUE	Deleted from CPT
93	Complete	TRUE	Deleted from CPT
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
		TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Increase
93	Complete	TRUE	Maintain
93	Complete	TRUE	Deleted from CPT
93	Complete	TRUE	Increase
		FALSE	
		TRUE	Increase
34	complete	TRUE	Deleted from CPT
EC-T Issue	complete	TRUE	Increase
EC-T Issue	complete	TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
35		FALSE	

		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
44		TRUE	Decrease
44		TRUE	Decrease
44	Code Deleted	TRUE	Deleted from CPT
		TRUE	Maintain
26	Complete	TRUE	Deleted from CPT
22		TRUE	Decrease
22		TRUE	Decrease
22	complete	TRUE	Deleted from CPT
22		TRUE	Deleted from CPT
55	Complete	TRUE	Decrease
55	Complete	TRUE	Decrease
55	Complete	TRUE	Decrease
		TRUE	Decrease
87	Complete	TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
24	yes	TRUE	Deleted from CPT
		FALSE	
	Complete	TRUE	Decrease
20	Complete	TRUE	Decrease
20	Complete	FALSE	Maintain
		TRUE	Maintain
28	Complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
28	Complete	TRUE	Increase
28	Complete	TRUE	Increase
28	Complete	TRUE	Increase
28	Complete	TRUE	Increase
		TRUE	Decrease
54	Complete	TRUE	Increase
54	Complete	TRUE	Increase
		TRUE	Decrease
54	Complete	TRUE	Maintain
54	Complete	TRUE	Increase
54	Complete	TRUE	Deleted from CPT
54	Complete	TRUE	Increase
54	Complete	TRUE	Increase
87	Complete	TRUE	Maintain
87	Complete	TRUE	Maintain
35	complete	TRUE	Increase
35	complete	TRUE	Increase
		TRUE	Decrease

54	Complete	TRUE	Decrease
		TRUE	Increase
54	Complete	TRUE	Decrease
54	Complete	TRUE	Decrease
54	Code Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Increase
19	complete	TRUE	Deleted from CPT
19	complete	TRUE	Deleted from CPT
41	Complete	TRUE	Increase
		TRUE	Increase
		TRUE	Decrease
58	Complete	TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
58		TRUE	Increase
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
34	Yes	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
19	complete	TRUE	Decrease
19	complete	TRUE	Increase
19	complete	TRUE	Increase
19	complete	TRUE	Increase
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
21	Complete	TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
21	Deleted from C	TRUE	Deleted from CPT
21	Deleted from C	TRUE	Deleted from CPT

21	Deleted from C	TRUE	Deleted from CPT
21	Deleted from C	TRUE	Deleted from CPT
		TRUE	Remove from Screen
16	yes	TRUE	Deleted from CPT
16	yes	TRUE	Deleted from CPT
21	Deleted from C	TRUE	Deleted from CPT
21	Deleted from C	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Maintain
57		TRUE	Deleted from CPT
57		TRUE	Deleted from CPT
42	Complete	TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
42	Complete	TRUE	Maintain
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
57	Revised	TRUE	Maintain
57		TRUE	Maintain
57		TRUE	Maintain
57	Revised	TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
57	Deleted	TRUE	Deleted from CPT
57		TRUE	Deleted from CPT
57		TRUE	Deleted from CPT
57	Deleted	TRUE	Deleted from CPT
57		TRUE	Deleted from CPT
57	Deleted	TRUE	Deleted from CPT
57	Complete	TRUE	Deleted from CPT
57		TRUE	Maintain
57		TRUE	PE Only
57		TRUE	PE Only
57		TRUE	Maintain
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Decrease
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Maintain

Advisory C	yes	TRUE	Decrease
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Decrease
Advisory C	yes	TRUE	Maintain
Advisory C	yes	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
Advisory C	yes	TRUE	PE Only
		TRUE	Maintain
		TRUE	Maintain
20	complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
42	Complete	TRUE	Decrease
		TRUE	Maintain
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13	Deleted	TRUE	Deleted from CPT
		TRUE	Decrease
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT

13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
13	Deleted	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Increase
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13		TRUE	Decrease
13	Complete	TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
22	Complete	TRUE	Maintain
		TRUE	Decrease
EC-N	Complete	TRUE	Decrease
13	Complete	TRUE	Maintain
22	Complete	TRUE	Deleted from CPT
22	Complete	TRUE	Deleted from CPT
22	Complete	FALSE	Decrease
22	Complete	FALSE	Decrease
22	Complete	FALSE	Decrease
61	complete	FALSE	Decrease
22	Complete	FALSE	Decrease
		TRUE	Decrease
		TRUE	PE Only
		TRUE	Remove from Screen
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Decrease
08	yes	TRUE	PE Only
08	yes	TRUE	Maintain
43	Complete	TRUE	Deleted from CPT
43	Complete	TRUE	Increase
		TRUE	Increase
CCI edits	Complete	TRUE	Increase
CCI edits	Complete	TRUE	Increase
		TRUE	Remove from Screen
		TRUE	Remove from Screen
		TRUE	Not Part of RAW

58	Revised	TRUE	Maintain
58	Revised	TRUE	Maintain
58	Revised	TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase
		TRUE	Increase
CCI edits	Complete	TRUE	Increase
28	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Deleted from CPT
36		TRUE	Increase
36		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
		TRUE	Remove from Screen
		TRUE	Remove from Screen
		TRUE	Remove from Screen
		TRUE	Decrease
		TRUE	Decrease
44	Complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
44	Complete	TRUE	Deleted from CPT
44	Complete	TRUE	Deleted from CPT
44	Complete	TRUE	Deleted from CPT
44	Complete	TRUE	Deleted from CPT
49	yes	TRUE	Deleted from CPT
		TRUE	Remove from Screen
39	Complete	TRUE	Decrease
39	Complete	TRUE	Decrease
39	Complete	TRUE	Deleted from CPT
39	Complete	TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Remove from Screen
44	Complete	TRUE	Deleted from CPT
44	Complete	TRUE	Deleted from CPT
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease

		TRUE	Deleted from CPT
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
49	yes	TRUE	Deleted from CPT
		TRUE	Maintain
15	Complete	TRUE	Deleted from CPT
		TRUE	PE Only
15	Complete	TRUE	Deleted from CPT
15	Complete	TRUE	Decrease
15	Complete	TRUE	Decrease
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
EC	yes	TRUE	PE Only
38	yes	TRUE	PE Only
38	yes	TRUE	Decrease
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	PE Only
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease

		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Deleted from CPT
39	complete	TRUE	Deleted from CPT
39	complete	TRUE	Deleted from CPT
39	complete	TRUE	Deleted from CPT
39	complete	TRUE	Deleted from CPT
09	Complete	TRUE	Maintain
09	Complete	TRUE	Maintain
09	Complete	TRUE	Maintain
09	Complete	TRUE	Maintain
06	Complete	TRUE	Maintain
06	Complete	TRUE	Maintain
06	Complete	TRUE	Maintain
06	Complete	TRUE	Maintain
09	Complete	TRUE	Decrease
09	Complete	TRUE	Decrease
09	Complete	TRUE	Decrease
06 & 16	Complete	TRUE	Deleted from CPT
06 & 16	Complete	TRUE	Deleted from CPT
09 & 16	Complete	TRUE	Deleted from CPT
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
17	Complete	TRUE	Maintain
17	Complete	TRUE	Maintain
		FALSE	Maintain
17	Complete	TRUE	Decrease
48	Complete	TRUE	Maintain
48	Complete	TRUE	Maintain
48	Complete	TRUE	Maintain
48	Complete	TRUE	Maintain
29	Complete	TRUE	Maintain
06 & 16	Complete	TRUE	Deleted from CPT

06 & 16	Complete	TRUE	Deleted from CPT
48	Complete	TRUE	Decrease
48	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
16	Complete	TRUE	Decrease
65	complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
35	Yes	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Remove from Screen
		TRUE	Deleted from CPT
		TRUE	Maintain
31	Complete	TRUE	Maintain
75, 31	Complete	TRUE	Maintain
EC1	Complete	TRUE	Decrease
75	Complete	TRUE	Deleted from CPT
31	Complete	TRUE	Deleted from CPT
31	Complete	TRUE	Deleted from CPT
31		TRUE	Maintain
31		TRUE	Maintain
31	Complete	TRUE	Deleted from CPT
31	Complete	TRUE	Deleted from CPT
31	Complete	TRUE	Maintain
31	Complete	TRUE	Maintain
31	Complete	TRUE	Maintain
31		TRUE	Maintain
31		TRUE	Maintain
	Complete	TRUE	Maintain
	Complete	TRUE	Maintain
		TRUE	Maintain
32	complete	TRUE	Deleted from CPT
32	complete	TRUE	Deleted from CPT
32	complete	TRUE	Deleted from CPT
32	complete	TRUE	Decrease
32	complete	TRUE	PE Only
32	complete	TRUE	Deleted from CPT
32	complete	TRUE	Decrease
32	complete	TRUE	Decrease
32	complete	TRUE	Maintain
32	complete	TRUE	Deleted from CPT
32	complete	TRUE	Deleted from CPT
32	complete	TRUE	Deleted from CPT
32	complete	TRUE	Decrease
32	complete	TRUE	Maintain
32	complete	TRUE	PE Only
32	complete	TRUE	Decrease
32	complete	TRUE	Decrease

32	complete	TRUE	Decrease
32	complete	TRUE	Decrease
32		TRUE	Decrease
32		TRUE	Decrease
32		TRUE	PE Only
32		TRUE	PE Only
32		TRUE	PE Only
40	Complete	TRUE	Deleted from CPT
40	Complete	TRUE	Deleted from CPT
40	Complete	TRUE	Deleted from CPT
40	Complete	TRUE	Deleted from CPT
40	Complete	TRUE	Deleted from CPT
40	Complete	TRUE	Deleted from CPT
40	Complete	TRUE	Increase
40	Complete	TRUE	Increase
40	Complete	TRUE	Increase
40	Complete	TRUE	Increase
40	Complete	TRUE	Increase
40	Complete	TRUE	Increase
40	Complete	TRUE	Increase
40	Complete	TRUE	Increase
40	Complete	TRUE	Increase
N/A	N/A	TRUE	Maintain
N/A	N/A	TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
N/A	N/A	TRUE	Maintain
N/A	N/A	TRUE	Maintain
N/A	N/A	TRUE	Maintain
N/A	N/A	TRUE	Not Part of RAW
N/A	N/A	TRUE	Maintain
N/A	N/A	TRUE	Maintain
		TRUE	PE Only
		TRUE	PE Only
N/A	N/A	TRUE	Maintain
N/A	N/A	TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Maintain
		TRUE	PE Only
78	yes	TRUE	Maintain
78	yes	TRUE	Increase
78	yes	TRUE	Increase
		TRUE	PE Only

		TRUE	Maintain
		TRUE	Increase
		TRUE	Maintain
88	Complete	TRUE	Deleted from CPT
88	Complete	TRUE	Deleted from CPT
88	Complete	TRUE	Deleted from CPT
88	Complete	TRUE	Deleted from CPT
		TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
cine and Re	survey existing	TRUE	Maintain
ssment Wo	survey existing	TRUE	Maintain
ssment Wo	survey existing	TRUE	Increase
ssment Wo	survey existing	TRUE	Increase
ssment Wo	survey existing	TRUE	Increase
80	yes	TRUE	Decrease
ssment Wo	survey existing	TRUE	Maintain
	survey existing	TRUE	Increase
88	Complete	TRUE	Decrease
88	Complete	TRUE	Decrease
88	Complete	TRUE	Maintain
88	Complete	TRUE	Increase
88	Complete	TRUE	Decrease
88	Complete	TRUE	Maintain
88	Complete	TRUE	Increase
88	Complete	TRUE	Increase
ssment Wo	survey existing	TRUE	Maintain
80	yes	TRUE	Deleted from CPT
sment Wo	survey existing	TRUE	Increase
sment Wo	survey existing	TRUE	Maintain
sment Wo	survey existing	TRUE	Increase
ssment Wo	survey existing	TRUE	Increase
mended th	N/A	TRUE	Increase
mended th	N/A	TRUE	Increase
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Remove from screen

81	yes	TRUE	Increase
81	yes	TRUE	Increase
81	yes	TRUE	Deleted from CPT
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
24	Complete	TRUE	PE Only
24	Complete	TRUE	PE Only
		TRUE	Decrease
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Increase
		TRUE	Maintain
11		FALSE	
11		FALSE	
08	yes	TRUE	Deleted from CPT
08	yes	TRUE	Deleted from CPT
		TRUE	Remove from screen
		TRUE	Remove from screen
		TRUE	Not part of RAW
		FALSE	
		FALSE	
		FALSE	
		FALSE	
		FALSE	
		TRUE	Remove from Screen
		TRUE	Remove from screen
16	Complete	TRUE	Decrease

		TRUE	Decrease
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Decrease
		TRUE	Maintain
		TRUE	Remove from Screen
		TRUE	Maintain
		TRUE	PE Only
		TRUE	Maintain
G codes are developed. CM		TRUE	Remove from screen
G codes are developed. CM		TRUE	Remove from screen
G codes are developed. CM		TRUE	Remove from screen
		TRUE	Remove from screen
38	Complete	TRUE	Deleted from CPT
38	Complete	TRUE	Deleted from CPT
38	Complete	TRUE	Deleted from CPT
		TRUE	Remove from Screen
		TRUE	Remove from Screen
08	yes	TRUE	Deleted from CPT
08	yes	TRUE	Deleted from CPT
08	yes	TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Remove from Screen
ssment Workgroup review		TRUE	Maintain
		FALSE	
12	Complete	TRUE	Deleted from CPT
		TRUE	Deleted from CPT
36	complete	TRUE	Deleted from CPT
23	Complete	TRUE	Deleted from CPT
		FALSE	
		TRUE	Deleted from CPT
		TRUE	Maintain
		TRUE	Maintain
		FALSE	
		FALSE	
		TRUE	Increase
		TRUE	Remove from screen
		TRUE	Remove from screen
		TRUE	Deleted from CPT
G codes are developed. CM		TRUE	Remove from screen
G codes are developed. CM		TRUE	Remove from screen
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Maintain
		TRUE	Increase

		TRUE	Remove from screen
28	Complete	TRUE	Deleted from CPT
28	complete	TRUE	Deleted from CPT
		TRUE	Remove from screen
		FALSE	
		FALSE	
		TRUE	Remove from screen
		FALSE	
		FALSE	
		TRUE	Remove from Screen
		FALSE	
		FALSE	
		TRUE	N/A
		TRUE	Maintain
		TRUE	Maintain

RUC Referrals to CPT Editoral Panel - Outstanding Issues

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
0446T	**Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training**	CMS Request - Final Rule for 2020	January 2020	AACE, ES	February 2021

Background: In the CY 2020 Final Rule, CMS sought information from stakeholders on the resources involved in furnishing the services described by Category III codes 0446T, 0447T and 0448T. CMS was specifically seeking recommendations, including the work RVUs, work time, and direct PE inputs, associated with the resources involved in inserting and removing the device, as well as the resource costs of the implantable device and disposable supplies. The Agency expressed concern for the immediate needs of Medicare beneficiaries with diabetes and stated that "the contractor pricing for these services has contributed to significant confusion in the community with regards to Medicare payment rules for these kinds of monitoring systems." Under existing policies of CMS, any recommendations submitted by February 10, 2020 would be considered for CY 2021 Physician Payment Schedule rulemaking. Accordingly, codes 0446T, 0447T and 0448T were placed on the RUC agenda for the January 2020 meeting. The specialty societies initially requested referral to the CPT Editorial Panel for Category III codes 0446T, 0447T and 0448T. These services were only approved by the FDA in June 2018 and have not yet been widely adopted, therefore a survey may not yield an accurate recommendation to CMS for consideration. It was also understood that this technology would be significantly revised over the next twelve months, which would result in the revision of these services and/or the development of additional codes for consideration. At the RUC meeting, however, the specialties indicated that they had reconsidered their request for referral because their discussions with the manufacturer indicated that it intended to convert the codes to Category I at some point in the future when the data and literature were available to support such an application.The RUC recommends that the codes remain contractor priced and that CPT codes 0446T, 0447T and 0448T be referred to the CPT Editorial Panel time uncertain.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
0447T	**Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision**	CMS Request - Final Rule for 2020	January 2020	AACE, ES	February 2021

Background: In the CY 2020 Final Rule, CMS sought information from stakeholders on the resources involved in furnishing the services described by Category III codes 0446T, 0447T and 0448T. CMS was specifically seeking recommendations, including the work RVUs, work time, and direct PE inputs, associated with the resources involved in inserting and removing the device, as well as the resource costs of the implantable device and disposable supplies. The Agency expressed concern for the immediate needs of Medicare beneficiaries with diabetes and stated that "the contractor pricing for these services has contributed to significant confusion in the community with regards to Medicare payment rules for these kinds of monitoring systems." Under existing policies of CMS, any recommendations submitted by February 10, 2020 would be considered for CY 2021 Physician Payment Schedule rulemaking. Accordingly, codes 0446T, 0447T and 0448T were placed on the RUC agenda for the January 2020 meeting. The specialty societies initially requested referral to the CPT Editorial Panel for Category III codes 0446T, 0447T and 0448T. These services were only approved by the FDA in June 2018 and have not yet been widely adopted, therefore a survey may not yield an accurate recommendation to CMS for consideration. It was also understood that this technology would be significantly revised over the next twelve months, which would result in the revision of these services and/or the development of additional codes for consideration. At the RUC meeting, however, the specialties indicated that they had reconsidered their request for referral because their discussions with the manufacturer indicated that it intended to convert the codes to Category I at some point in the future when the data and literature were available to support such an application.The RUC recommends that the codes remain contractor priced and that CPT codes 0446T, 0447T and 0448T be referred to the CPT Editorial Panel time uncertain.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
0448T	**Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation**	CMS Request - Final Rule for 2020	January 2020	AACE, ES	February 2021

Background: In the CY 2020 Final Rule, CMS sought information from stakeholders on the resources involved in furnishing the services described by Category III codes 0446T, 0447T and 0448T. CMS was specifically seeking recommendations, including the work RVUs, work time, and direct PE inputs, associated with the resources involved in inserting and removing the device, as well as the resource costs of the implantable device and disposable supplies. The Agency expressed concern for the immediate needs of Medicare beneficiaries with diabetes and stated that "the contractor pricing for these services has contributed to significant confusion in the community with regards to Medicare payment rules for these kinds of monitoring systems." Under existing policies of CMS, any recommendations submitted by February 10, 2020 would be considered for CY 2021 Physician Payment Schedule rulemaking. Accordingly, codes 0446T, 0447T and 0448T were placed on the RUC agenda for the January 2020 meeting. The specialty societies initially requested referral to the CPT Editorial Panel for Category III codes 0446T, 0447T and 0448T. These services were only approved by the FDA in June 2018 and have not yet been widely adopted, therefore a survey may not yield an accurate recommendation to CMS for consideration. It was also understood that this technology would be significantly revised over the next twelve months, which would result in the revision of these services and/or the development of additional codes for consideration. At the RUC meeting, however, the specialties indicated that they had reconsidered their request for referral because their discussions with the manufacturer indicated that it intended to convert the codes to Category I at some point in the future when the data and literature were available to support such an application.The RUC recommends that the codes remain contractor priced and that CPT codes 0446T, 0447T and 0448T be referred to the CPT Editorial Panel time uncertain.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37220	**Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37221	**Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37222	**Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37223	**Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37224	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37225	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37226	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37227	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37228	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37229	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37230	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37231	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37232	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37233	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37234	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37235	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	September 2021

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
49565	**Repair recurrent incisional or ventral hernia; reducible**	Site of Service Anomaly - 2019	January 2020	ACS, SAGES	February 2021

Background: In October 2019, the Relativity Assessment Workgroup identified CPT code 49565 as performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period with 2018e Medicare utilization over 5,000. The RUC recommended this service be surveyed for January 2020. In January 2020, the specialty societies requested that CPT code 49565 be referred to the May 2020 CPT Editorial Panel to update the descriptor to current standard of practice and typical patient presentation; for example, mesh insertion and removal, and size and number or defects. The RUC questioned if CPT codes 49560, 49561, 49566 and/or 49568 are considered part of this family of services. The specialty society indicated they will define the family of services on the correct coding application (CCA). The RUC recommends that these services be referred to the May 2020 CPT Editorial Panel. The specialties are will submit a CCA for the CPT 2023 cycle.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
50080	**Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm**	Site of Service Anomaly - 2019	January 2020	AUA	May 2021

Background: In January 2020, the specialty societies requested that CPT codes 50080 and 50081 be referred to the CPT Editorial Panel to update the descriptors to remove the phrase "with or without" and clearly differentiate work in current practice. October 2020 CPT Editorial Panel postponed this issue until February 2021.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
50081	**Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm**	Site of Service Anomaly - 2019	January 2020	AUA	May 2021

Background: In January 2020, the specialty societies requested that CPT codes 50080 and 50081 be referred to the CPT Editorial Panel to update the descriptors to remove the phrase "with or without" and clearly differentiate work in current practice. October 2020 CPT Editorial Panel postponed this issue until February 2021.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
63030	**Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar**	Pre-Time Analysis / Site of Service Anomaly - 2018	January 2021	AANS, AAOS, NASS	May 2021

Background: CPT code 63030 was identified via the site of service anomaly screent. In December 2020, the Relativity Assessment Workgroup noted that CPT code 63030 continues to be primarily reported in the outpatient setting yet still includes inpatient hospital visits. The specialty society indicated that there is still confusion, and 63030 is inappropriately being reporting in the outpatient setting. The RUC recommends that CPT code 63030 be referred to CPT (May 2021) to revise the descriptor to exclude the types of procedures that are thought to be causing the incorrect reporting in the outpatient setting, such as explicitly stating the types of situations for which CPT code 63030 should not be used. The RUC understands that this service will be surveyed after the CPT revisions and reviewed by the RUC.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64415	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus**	CMS Fastest Growing	October 2018	AAPM, ASA	May 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64416	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)**	Site of Service Anomaly / High Volume Growth2	October 2018	ASA	May 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64417	**Injection(s), anesthetic agent(s) and/or steroid; axillary nerve**	part of New/Revised Review	October 2018	ASA	May 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64446	**Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)**	Site of Service Anomaly / High Volume Growth1	October 2018	ASA	May 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64447	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve**	CMS Fastest Growing	October 2018	AAPM, ASA	May 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
64448	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)**	Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2	October 2018	ASA	May 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
73580	**Radiologic examination, knee, arthrography, radiological supervision and interpretation**	High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3	October 2020	AAOS	May 2021

Background: The Workgroup discussed the long history of the identification of code 73580 and noted that this service has never been surveyed and remains CMS/Other sourced. The specialty societies noted that the increased utilization was due to miscoding of the related CPT code 27370 Injection of contrast for knee arthrography. To address this miscoding, CPT code 27370 was deleted and replaced with a new CPT code 27369 Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography. The new CPT code was valued by the RUC in October 2017. CPT code 27370 was deleted in 2019 and a CPT Assistant article was published in August 2019. CPT code 73580 utilization has decreased in 2019 concurrent with the deletion of 27370 and clarification of the appropriate use of these codes. The specialty societies noted that the RUC rationale for CPT code 27369 provides additional information, including why these services were not previously bundled. However, the Workgroup noted that codes 73580 and 27369 will always be reported in conjunction with one another. The Workgroup also noted that that Rheumatology and Family Medicine are the primary providers of code 73580 and should be involved with the review of this service. The Workgroup recommends that CPT code 73580 be referred to CPT to be bundled with CPT code 27369 Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
76377	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation**	CMS Request - Final Rule for 2020	January 2020	ACR, ASNR, SIR	May 2021

Background: In the Final Rule for the CY 2020 Medicare Physician Fee Schedule, CMS nominated CPT code 76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation as potentially misvalued. The Agency views CPT code 76377 to be part of the same family as CPT code 76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation, which was recently reviewed at the April 2018 RUC meeting. CMS requested that CPT code 76376 also be reviewed to maintain relativity within the code family. The specialty societies disagreed with CMS' rationale for the nomination of CPT code 76377 as potentially misvalued and the specialties do not believe that CPT codes 76376 and 76377 are in the same code family, although the descriptors are similar. The societies noted that the two codes are different because they are utilized on different patient populations (as evidenced by the ICD-10 diagnoses.) They also noted that the technical and professional resources required for 76376 and 76377 are significantly different. For these reasons, the specialty societies recommended, and the RUC agreed to refer CPT codes 76377 and 76376 to the CPT Editorial Panel for further review and potential revision. The specialty societies noted that they will determine the family of services including whether the codes remain a family, based on the recommendations of the CPT Editorial Panel.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
76942	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**	CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3	April 2014	AACE, AAOS, AAPMR, ACR, ACRh, APMA, ASA, ASBS, ASIPP, AUA, SIR	May 2021

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 64447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completes its work.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
76998	**Ultrasonic guidance, intraoperative**	CMS-Other - Utilization over 20,000 Part1	October 2019	STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS	September 2021

Background: In October 2018, the Workgroup discussed future screens and recommends lowering the threshold and examining the list of CMS/Other source codes with Medicare utilization over 20,000. In October 2019, the RUC refers this issued to CPT Editorial Panel (May 2020) to more accurately differentiate physician work as multiple specialties currently use this code and to clarify correct coding.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
92065	**Orthoptic and/or pleoptic training, with continuing medical direction and evaluation**	Harvard Valued - Utilization over 30,000-Part4	October 2020	AAO, AOA (optometry)	February 2021 May 2020-Tab 37

Background: This service was identified in October 2019 as Harvard Valued utilization over 30,000. The Workgroup requested action plans to examine this service. In January 2020, the RUC recommended that this service be referred to CPT May 2020. This service with an “and/or” connector should be two different codes given their different patient populations and techniques used for the treatment. For that reason, this code should go back to CPT for a descriptor edit as well as creation of separate codes. At the October 2020 RUC meeting, based on pre-facilitation by the RUC, the specialty societies indicated their intent to take this code back to the CPT Editorial Panel to create two separate codes. The societies requested referral to CPT and plan to submit a new code change application for the February 2021 CPT Editorial Panel meeting. During review and analysis of the survey, it became evident that this service is delivered in two different ways. Because of this, it is necessary to create two codes in order to delineate when the training is provided directly by the provider and when it is provided by a technician under the supervision of the provider. Doing so will ensure more accurate valuation of both work and practice expense associated with this service. The RUC supports creation of a companion code and concurs that code 92065 should be referred to the February 2021 CPT Editorial Panel meeting for CPT 2023. The RUC recommends CPT code 92065 be referred to CPT.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99358	**Prolonged evaluation and management service before and/or after direct patient care; first hour**	CMS Request - Final Rule for 2020	October 2020	AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE	February 2021

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99359	**Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)**	CMS Request - Final Rule for 2020	October 2020	AAAAI, AACAP, AAFP, AAHPM, AAN, AAP, ACP, ACRh, AGS, ANA, ASE	February 2021

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
G0396	**Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes**	CMS-Other - Utilization over 30,000	January 2018	AAFP, ASA, ASAM	Time Uncertain

Background: In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. This list resulted in 34 services and the RAW requested action plans to be reviewed at the January 2018 meeting. In January 2018, the RUC recommended to maintain the physician work and refer to CPT to editorially remove "screening" from 99408 and 99409 to "assessment" to mirror G0396. At the February 2018 CPT meeting, the Panel postponed until time uncertain this request to revise codes 99408-99409 to identify assessment of alcohol and/or substance abuse. As a rationale for postponement, the Panel said that the service described in this application did not meet the General Criteria for Category I because the proposed service is not unique or well defined, and does not describe a service that is clearly identified and distinguished from existing services already described in CPT by other codes. The Panel's additional rationale for postponement of this item was to allow the relevant specialty societies an opportunity to submit a new code change application to address the differences between assessment and screening services.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
G6001	**Ultrasonic guidance for placement of radiation therapy fields**	CMS-Other - Utilization over 20,000 Part2	January 2021		September 2021

Background: The RUC identified G6001 via the CMS/Other Source Utilization over 20,000 screen. In January 2021, the RUC recommended to refer to CPT to develop new code(s) that reflect the different process of care between the two specialties (dermatology and radiation oncology).

RUC Recommendations to Develop CPT Assistant Articles - Outstanding Issues

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
63685	**Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**	Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7	January 2021	Refer to CPT Assistant. Review action plan in 2 years after CPT article published. 6.05	AAPM, AANS/CNS, ASA, ISIS, NASS	

Background: Oct 2010 re-reviewed site of service issue. In October 2020, the RUC identified six codes with Medicare utilization of 10,000 or more that have increased by at least 100% from 2014 through 2019e. CPT codes 00918, 63685, 75561, 75572, 75574 and 93655. The Workgroup requested that the specialty societies submit an action plan for codes CPT codes 00918, 63685, 75561, 75572, 75574 and 93655 for January 2021. In January 2021, the RUC recommended to refer to CPT Assistant. A CPT Assistant article has already been submitted. The RUC will reeview after 2 years of data are available after article is published.

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
75710	**Angiography, extremity, unilateral, radiological supervision and interpretation**	CMS High Expenditure Procedural Codes2	January 2021	Refer to CPT Assistant and review after 2 years of data after publication available. 1.75	ACR, ACC, RPA, SCAI, SIR, SVS	

Background: In the NPRM for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. In October 2016 the RUC noted that with the newly bundled dialysis access maintenance codes that were approved in January 2016 as part of Dialysis Circuit code family 36901-36909, the specialties project that a significant portion of the nephrology volume for 75710 will instead be reported with applicable Dialysis Circuit codes. Nephrology represented 17.8 percent of the 2015 Medicare claims for 75710. The RUC will add a flag for review to confirm that nephrology utilization volume has decreased once 2017 Medicare utilization data is available for review. The RUC noted the nephrology utilization is slightly decreasing. The RUC recommended to review utilization again in 2 years (Oct 2020). In October 2020, the Workgroup reviewed the history of this code and the action plan submitted by SVS, SIR, ACR and ACC. Noting that the 2019e utilization by nephrologists was gradually decreasing (13%) (global & -26 modifier). The Workgroup questioned if the gradual decrease in utilization by nephrologists is appropriate or if nephrologists should not be performing this service at all. The Workgroup noted that RPA was not involved in the development of this action plan. The Workgroup requested the input from Nephrology regarding the reporting of CPT code 75710 and review at the January 2021 meeting. In January 2021, the Relativity Assessment Workgroup noted that the utilization of nephrology continues to decrease but not at the rate the specialty societies thought it would. The specialty societies indicated that they would submit a CPT Assistant article to address the appropriate reporting of this service. The Workgroup recommends that this service be referred to CPT Assistant and reviewed after 2 years of data is available after the publication of the article. The specialty societies noted that the expected utilization for Nephrology would be under 10%.

Physician Time from RUC Meeting:
January 2021 (CPT 2022)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
21315	30	3	10	15	10													68
21320	30	3	10	20	12													75
22867	33	15	15	90	30			3						0.5				271
33361	50	15	20	90	30											1		275
33362	50	15	20	103	45											1		303
33363	50	15	20	100	45											1		300
33364	50	15	20	94	45											1		294
33365	50	15	20	120	45											1		320
33366	50	15	20	120	45											1		320
33367				90														90
33368				120														120
33369				160														160
33370				20														20
33509				35														35
33894	60	15	15	134	60													284
33895	50	15	15	120	60													260
33897	50	15	15	90	60													230
35600				40														40
42975	18	1	6	15	28													68
61736	68	30	15	180	60													353
61737	93	36	15	235	40								1					474
63052				40														40
63053				30														30
64582	35	20	14	140	20			2						0.5				294
64583	40	20	14	150	20			2						0.5				309
64584	40	15	15	120	20			2						0.5				275
64628	33	10	13	60	20			1						0.5				178
64629				60														60
66174	13	1	6	20	6		1	4						0.5				173
66175	13	1	6	30	7		1	4						0.5				184
66982	25	3	7	30	6		1	3						0.5				175
66984	13	1	6	20	5		1	2						0.5				126
66987	30	3	10	36	10		1	5						0.5				239
66988	25	3	10	30	7		1	4						0.5				202
66989	26	3	7	28	8		1	3						0.5				176
66991	25	3	7	25	8		1	3						0.5				172
68841	5	1	1	3	2													12
69714	33	3	10	40	15		1	2						0.5				182
69716	32	3	10	60	15			2						0.5				185
69717	33	3	10	45	15		1	2						0.5				187
69719	33	3	10	60	15			2						0.5				186
69726	32	3	10	30	15		1	1						0.5				148
69727	33	3	10	45	15		1	1						0.5				164

Physician Time from RUC Meeting:
January 2021 (CPT 2022)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
77089	2			5	2													9
77092	2			5	2													9
80503				15														15
80504				30														30
80505				54														54
80506				30														30
91110	5			40	10													55
91111	5			15	5													25
91113	5			45	10													60
93653	40	3	15	125	30													213
93654	40	3	20	240	33													336
93655				60														60
93656	40	3	20	210	33													306
93657				60														60
94625	2			9	10													21
94626	2			14	10													26
98980				20														20
98981				20														20
99424				32														32
99425				30														30
99426				25														25
99427				20														20
99437				30														30
99439				20														20
99487				45														45
99489				30														30
99490				25														25
99491				33														33
0021A				7														7
0022A				7														7
01937	10		7	17	8													42
01938	10		7	17	8													42
01939	11		7	17	10													45
01940	11		7	17	10													45
01941	13		7	28	10													58
01942	13		7	28	10													58

Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY				NON-FAC	
		1	2	3	4	5**	6
	Total Pre-Service Time	**20**	**25**	**51**	**63**	**8**	**23**
	CATEGORY SUBTOTALS						
A	Pre-Service Evaluation (IWPUT =0.0224)	13	18	33	40	7	17
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	3	3	0	1
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	6	15	20	1	5
	DETAILS						
A	History and Exam (Performance and review of appropriate Pre-Tests)	5	10	10	15	4	9
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	4	1	1
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	5	5	2	3
A	Communicate with other professionals	0	0	5	5	0	2
A	Check/set-up room, supplies and equipment	1	1	5	5	0	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	5	5	0	1
A	Prepare/ review/ confirm procedure	1	1	1	1	0	0
B	Perform/ supervise patient positioning	1	1	3	3	0	1
C	Administer local/topical anesthesia	1	1	0	0	1	5
C	Observe (wait anesthesia care)	0	0	10	15	0	0
C	Dress and scrub for procedure	5	5	5	5	0	0

**If the procedure does not require local anesthesia, 1 minute should be removed from pre-service time

- **1** Straightforward Patient/Straightforward Procedure (No anesthesia care)
- **2** Difficult Patient/Straightforward Procedure (No anesthesia care)
- **3** Straightforward Patient/Difficult Procedure
- **4** Difficult Patient/Difficult Procedure
- **5** Procedure with minimal anesthesia care (If no anesthesia care deduct 1 minute)
- **6** Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect

Additional Positioning Times for Spinal Surgical Procedures

SS1	Anterior Neck Surgery (Supine) (eg ACDF)	15 Minutes
SS2	Posterior Neck Surgery (Prone) (eg laminectomy)	25 Minutes
SS3	Posterior Thoracic/Lumbar (Prone) (eg laminectomy)	15 Minutes
SS4	Lateral Thoracic/Lumbar (Lateral) (eg corpectomy)	25 Minutes
SS5	Anterior Lumbar (Supine) (eg ALIF)	15 Minutes

Additional Positioning Times for Spinal Injection Procedures

SI1	Anterior Neck Injection (Supine) (eg discogram)	7 Minutes
SI2	Posterior Neck Injection (Prone) (eg facet)	5 Minutes
SI3	Posterior Thoracic/Lumbar (Prone) (eg epidural)	5 Minutes
SI4	Lateral Thoracic/Lumbar (Lateral) (eg discogram)	7 Minutes

Additional Positioning Times for Urological Procedures

U1	Dorsal Lithotomy	5 Minutes

Notes:

- Roll-over cells for additional detail where available
- Straightforward procedure: Integumentary, Non-incisional endoscopy, natural orifice

Detailed Description of Facility Based Post-Service Time Packages (Minutes)						
	7A Local Anesthesia/ Straightforward Procedure	**7B Local Anesthesia/ Complex Procedure**	**8A IV Sedation/ Straightforward Procedure**	**8B IV Sedation/ Complex Procedure**	**9A General Anesthesia or Complex Regional Block/ Straightforward Procedure**	**9B General Anesthesia or Complex Regional Block/Complex Procedure**
Total Post-Service Time	**18**	**21**	**25**	**28**	**30**	**33**
Details:						
Application of Dressing[1]	2	2	2	2	2	2
Transfer of supine patient off table	1	1	1	1	1	1
Operative Note	5	5	5	5	5	5
Monitor patient recovery/stabilization	1	1	5	5	10	10
Communication with patient and/or family	5	5	5	5	5	5
Written post-operative note	2	5	2	5	2	5
Post-Operative Orders and Order Entry	2	2	5	5	5	5

Advisors may request additional time for circumstances that require additional work beyond the type of work described

1 This represents a simple dressing

CPT	RUC Recommended PLI Crosswalk
21315	21315
21320	21320
22867	22867
33361	33361
33362	33362
33363	33363
33364	33364
33365	33365
33366	33366
33367	33367
33368	33368
33369	33369
33370	33361
33509	35600
33894	93530
33895	93530
33897	93530
35600	35600
42975	31573
61736	63194
61737	63194
63052	63066
63053	63066
64582	69930
64583	69930
64584	69930
64628	63650
64629	64634
66174	66174
66175	66175
66982	66982
66984	66984
66987	66987
66988	66988
66989	66982
66991	66984
68841	66984
69714	69714
69716	31070
69717	69717
69719	31070
69726	31070
69727	31070
77089	77081

77090	77081
77091	77081
77092	77081
80503	80500
80504	80502
80505	80502
80506	80502
91110	91110
91111	91111
91113	91110
93653	93653
93654	93654
93655	93655
93656	93656
93657	93657
94625	G0424
94626	G0424
98975	20553
98976	20553
98977	20553
98980	20553
98981	20553
99424	G2064
99425	G2064
99426	G2065
99427	G2065
99437	99491
99439	99490
99487	99487
99489	99489
99490	99490
99491	99491
0021A	90460
0022A	90460

CPT	BETOS Class	BETOS Subclass	BETOS Subclass2
21315	Procedures	Minor procedure	Musculoskeletal
21320	Procedures	Minor procedure	Musculoskeletal
22867	Procedures	Major procedure	Other
33361	Procedures	Major procedure	Cardiovascular-Other
33362	Procedures	Major procedure	Cardiovascular-Other
33363	Procedures	Major procedure	Cardiovascular-Other
33364	Procedures	Major procedure	Cardiovascular-Other
33365	Procedures	Major procedure	Cardiovascular-Other
33366	Procedures	Major procedure	Cardiovascular-Other
33367	Procedures	Major procedure	Cardiovascular-Other
33368	Procedures	Major procedure	Cardiovascular-Other
33369	Procedures	Major procedure	Cardiovascular-Other
33370	Procedures	Major procedure	Cardiovascular-Other
33509	Procedures	Major procedure	Cardiovascular-CABG
33894	Procedures	Major procedure	Cardiovascular-Other
33895	Procedures	Major procedure	Cardiovascular-Other
33897	Procedures	Major procedure	Cardiovascular-Other
35600	Procedures	Major procedure	Cardiovascular-CABG
42975	Procedures	Endoscopy	Other
61736	Procedures	Major procedure	Other
61737	Procedures	Major procedure	Other
63052	Procedures	Major procedure	Explor/Decompr/Excis disc
63053	Procedures	Major procedure	Explor/Decompr/Excis disc
64582	Procedures	Major procedure	Other
64583	Procedures	Major procedure	Other
64584	Procedures	Major procedure	Other
64628	Procedures	Major procedure	Other
64629	Procedures	Major procedure	Other
66174	Procedures	Eye procedure	Other
66175	Procedures	Eye procedure	Other
66982	Procedures	Eye procedure	Cataract removal/lens insertion
66984	Procedures	Eye procedure	Cataract removal/lens insertion
66987	Procedures	Eye procedure	Cataract removal/lens insertion
66988	Procedures	Eye procedure	Cataract removal/lens insertion
66989	Procedures	Eye procedure	Cataract removal/lens insertion
66991	Procedures	Eye procedure	Cataract removal/lens insertion
68841	Procedures	Eye procedure	Other
69714	Procedures	Major procedure	Other
69716	Procedures	Major procedure	Other
69717	Procedures	Major procedure	Other
69719	Procedures	Major procedure	Other
69726	Procedures	Major procedure	Other
69727	Procedures	Major procedure	Other
77089	Imaging	Standard imaging	Musculoskeletal
77090	Imaging	Standard imaging	Musculoskeletal
77091	Imaging	Standard imaging	Musculoskeletal
77092	Imaging	Standard imaging	Musculoskeletal
80503	Procedures	Specialist	Pathologist

80504	Procedures	Specialist	Pathologist
80505	Procedures	Specialist	Pathologist
80506	Procedures	Specialist	Pathologist
91110	Tests	Other tests	Other
91111	Tests	Other tests	Other
91113	Tests	Other tests	Other
93653	Procedures	Major procedure	Cardiovascular-Other
93654	Procedures	Major procedure	Cardiovascular-Other
93655	Procedures	Major procedure	Cardiovascular-Other
93656	Procedures	Major procedure	Cardiovascular-Other
93657	Procedures	Major procedure	Cardiovascular-Other
94625	Other	NA	NA
94626	Other	NA	NA
98975	Tests	Other tests	Other
98976	Tests	Other tests	Other
98977	Tests	Other tests	Other
98980	Tests	Other tests	Other
98981	Tests	Other tests	Other
99424	Evaluation Management	NA	NA
99425	Evaluation Management	NA	NA
99426	Evaluation Management	NA	NA
99427	Evaluation Management	NA	NA
99437	Evaluation Management	NA	NA
99439	Evaluation Management	NA	NA
99487	Evaluation Management	NA	NA
99489	Evaluation Management	NA	NA
99490	Evaluation Management	NA	NA
99491	Evaluation Management	NA	NA
0021A	Other	Immunizations/Vaccinations	NA
0022A	Other	Immunizations/Vaccinations	NA
01937	Procedures	Anesthesia	NA
01938	Procedures	Anesthesia	NA
01939	Procedures	Anesthesia	NA
01940	Procedures	Anesthesia	NA
01941	Procedures	Anesthesia	NA
01942	Procedures	Anesthesia	NA

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
01935	D	19,793	01937	1,386	0.070	5.00	4.00	04 Anesthesia Services for Image-Guided Spinal Procedures	5,544	6,930
01936	D	311,884	01937	18,713	0.060	5.00	4.00	04 Anesthesia Services for Image-Guided Spinal Procedures	74,852	93,565
01935	D	19,793	01938	16,626	0.840	5.00	4.00	04 Anesthesia Services for Image-Guided Spinal Procedures	66,504	83,130
01936	D	311,884	01938	62,377	0.200	5.00	4.00	04 Anesthesia Services for Image-Guided Spinal Procedures	249,508	311,885
01935	D	19,793	01939	198	0.010	5.00	4.00	04 Anesthesia Services for Image-Guided Spinal Procedures	792	990
01936	D	311,884	01939	40,545	0.130	5.00	4.00	04 Anesthesia Services for Image-Guided Spinal Procedures	162,180	202,725
01935	D	19,793	01940	792	0.040	5.00	4.00	04 Anesthesia Services for Image-Guided Spinal Procedures	3,168	3,960
01936	D	311,884	01940	96,684	0.310	5.00	4.00	04 Anesthesia Services for Image-Guided Spinal Procedures	386,736	483,420
01935	D	19,793	01941	396	0.020	5.00	6.00	04 Anesthesia Services for Image-Guided Spinal Procedures	2,376	1,980
01936	D	311,884	01941	46,783	0.150	5.00	6.00	04 Anesthesia Services for Image-Guided Spinal Procedures	280,698	233,915
01935	D	19,793	01942	396	0.020	5.00	6.00	04 Anesthesia Services for Image-Guided Spinal Procedures	2,376	1,980
01936	D	311,884	01942	46,783	0.150	5.00	6.00	04 Anesthesia Services for Image-Guided Spinal Procedures	280,698	233,915
21315		524	21315	524	1.000	1.83	2.00	05 Closed Treatment of Nasal Bone Fracture	1,048	959
21320		1,970	21320	1,970	1.000	1.88	2.33	05 Closed Treatment of Nasal Bone Fracture	4,590	3,704
22630		5,654	22630	5,654	1.000	22.09	22.09	06 Arthrodesis Decompression	124,897	124,897
22632		1,875	22632	1,875	1.000	5.22	5.22	06 Arthrodesis Decompression	9,788	9,788
22633		38,096	22633	38,096	1.000	27.25	27.25	06 Arthrodesis Decompression	1,038,116	1,038,116
22634		14,338	22634	14,338	1.000	8.16	8.16	06 Arthrodesis Decompression	116,998	116,998
63047		101,838	63052	11,000	0.108	7.69	5.55	06 Arthrodesis Decompression	61,050	84,535
63047		101,838	63047	90,838	0.892	7.69	7.69	06 Arthrodesis Decompression	698,090	698,090
63048		128,927	63053	4,000	0.031	3.47	4.44	06 Arthrodesis Decompression	17,760	13,880
63048		128,927	63048	124,927	0.969	3.47	3.47	06 Arthrodesis Decompression	433,497	433,497
93799		1,200	33370	100	0.083	0.00	2.50	Percutaneous Cerebral Embolic Protection - 07	250	0
93799		1,200	93799	800	0.667	0.00	0.00	Percutaneous Cerebral Embolic Protection - 07	0	0
33361		40,182	33361	40,182	1.000	22.47	22.47	Percutaneous Cerebral Embolic Protection - 07	902,890	902,890
33362		1,824	33362	1,824	1.000	24.54	24.54	Percutaneous Cerebral Embolic Protection - 07	44,761	44,761
33363		972	33363	972	1.000	25.47	25.47	Percutaneous Cerebral Embolic Protection - 07	24,757	24,757
33364		11	33364	11	1.000	25.97	25.97	Percutaneous Cerebral Embolic Protection - 07	286	286
33365		257	33365	257	1.000	26.59	26.59	Percutaneous Cerebral Embolic Protection - 07	6,834	6,834
33366		160	33366	160	1.000	29.35	29.35	Percutaneous Cerebral Embolic Protection - 07	4,696	4,696
33367		107	33367	107	1.000	11.88	11.88	Percutaneous Cerebral Embolic Protection - 07	1,271	1,271
33368		18	33368	18	1.000	14.39	14.39	Percutaneous Cerebral Embolic Protection - 07	259	259
33369		9	33369	9	1.000	19.00	19.00	Percutaneous Cerebral Embolic Protection - 07	171	171
93799		1,200	33894	100	0.083	0.00	21.70	Endovascular Repair of Aortic Coarctation - 08	2,170	0
93799		1,200	33895	100	0.083	0.00	17.97	Endovascular Repair of Aortic Coarctation - 08	1,797	0
93799		1,200	33897	100	0.083	0.00	14.00	Endovascular Repair of Aortic Coarctation - 08	1,400	0
35600		2,479	33509	1,081	0.436	4.94	3.75	Harvest of Upper Extremity Artery, Endoscopic and Open - Tab 9	4,053	5,339
35600		2,479	35600	1,398	0.564	4.94	4.00	Harvest of Upper Extremity Artery, Endoscopic and Open - Tab 9	5,593	6,907
31599		301	42975	100	0.332	0.00	1.90	10 Drug Induced Sleep Endoscopy	190	0
31599		301	31599	201	0.668	0.00	0.00	10 Drug Induced Sleep Endoscopy	0	0
0548T	D	13	53451	13	1.000	0.00	0.00	Periurethral Balloon Continence Device Procedures - Tab 11	0	0
0549T	D	1	53452	1	1.000	0.00	0.00	Periurethral Balloon Continence Device Procedures - Tab 11	0	0
0550T	D	7	53453	7	1.000	0.00	0.00	Periurethral Balloon Continence Device Procedures - Tab 11	0	0
0551T	D	16	53454	16	1.000	0.00	0.00	Periurethral Balloon Continence Device Procedures - Tab 11	0	0
64999		7,432	61736	372	0.050	0.00	20.00	Intracranial Laser Interstitial Thermal Therapy (LITT) - Tab 12	7,440	0
64999		7,432	61737	93	0.013	0.00	24.00	Intracranial Laser Interstitial Thermal Therapy (LITT) - Tab 12	2,232	0
64999		7,432	64999	6,967	0.937	0.00	0.00	Intracranial Laser Interstitial Thermal Therapy (LITT) - Tab 12	0	0
64568		1,002	64582	78	0.078	9.00	16.00	13 Hypoglossal Nerve Stimulator Services	1,248	702
0466T	D	78	Util Savings (Bundled into 64582)	78	1.000	0.00	0.00	13 Hypoglossal Nerve Stimulator Services	0	0
64568		1,002	64568	924	0.922	9.00	9.00	13 Hypoglossal Nerve Stimulator Services		

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
64569		150	64583	-	0.000	11.00	17.04	13 Hypoglossal Nerve Stimulator Services	0	0
0467T	D	-	Util Savings (Bundled into 64583)	-	1.000	0.00	0.00	13 Hypoglossal Nerve Stimulator Services	0	0
64569		150	64569	150	1.000	11.00	11.00	13 Hypoglossal Nerve Stimulator Services	1,650	1,650
64570		83	64584	-	0.000	9.10	14.00	13 Hypoglossal Nerve Stimulator Services	0	0
0468T	D	-	Util Savings (Bundled into 64584)	-	1.000	0.00	0.00	13 Hypoglossal Nerve Stimulator Services	0	0
64570		83	64570	83	1.000	9.10	9.10	13 Hypoglossal Nerve Stimulator Services	755	755
22899		633	64628	100	0.158	0.00	9.75	Destruction of Intraosseous Basivertebral Nerve – Tab 14	975	0
22899		633	64629	100	0.158	0.00	4.87	Destruction of Intraosseous Basivertebral Nerve – Tab 14	487	0
22899		633	22899	433	0.684	0.00	0.00	Destruction of Intraosseous Basivertebral Nerve – Tab 14	0	0
66174		10,214	66174	10,214	1.000	12.85	8.60	Dilation of Aqueous Outflow Canal – Tab 15	87,840	131,250
66175		223	66175	223	1.000	13.60	10.25	Dilation of Aqueous Outflow Canal – Tab 15	2,286	3,033
66982		159,924	66982	155,426	0.972	10.25	10.25	Cataract Removal with Drainage Device Insertion – Tab 16	1,593,114	1,593,114
66982		159,924	66989	4,498	0.028	10.25	12.13	Cataract Removal with Drainage Device Insertion – Tab 16	54,564	46,107
0191T	D	57,829	Util Savings (Bundled into 66989)	-	0.000	0.00	0.00	Cataract Removal with Drainage Device Insertion – Tab 16	0	0
66987		-	66987	-	1.000	0.00	13.15	Cataract Removal with Drainage Device Insertion – Tab 16	0	0
66984		1,694,951	66984	1,652,717	0.975	7.35	7.35	Cataract Removal with Drainage Device Insertion – Tab 16	12,147,473	12,147,473
66988		-	66988	-	1.000	0.00	10.25	Cataract Removal with Drainage Device Insertion – Tab 16	0	0
66984		1,694,951	66991	42,234	0.025	7.35	11.05	Cataract Removal with Drainage Device Insertion – Tab 16	466,681	310,417
0191T	D	57,829	Util Savings (Bundled into 66991)	-	0.000	0.00	0.00	Cataract Removal with Drainage Device Insertion – Tab 16	0	0
0191T	D	57,829	0671T	11,097	0.192	0.00	0.00	Cataract Removal with Drainage Device Insertion – Tab 16	0	0
0376T	D	16,708	Util Savings (Bundled into 0671T or 66989 or 66991)	16,708	1.000	0.00	0.00	Cataract Removal with Drainage Device Insertion – Tab 16		
0356T	D	-	68841	-	1.000	0.00	0.49	Lacrimal Canaliculus Drug Eluding Implant Insertion - Tab 17	0	0
69714		993	69714	993	1.000	14.45	8.69	18 Transcutaneous Passive Implant-Temporal Bone	8,629	14,349
69717		68	69717	68	1.000	15.43	8.80	18 Transcutaneous Passive Implant-Temporal Bone	598	1,049
69714		993	69716		0.000	14.45	9.77	18 Transcutaneous Passive Implant-Temporal Bone	0	0
69714		993	69719		0.000	14.45	9.77	18 Transcutaneous Passive Implant-Temporal Bone	0	0
69714		993	69726		0.000	14.45	5.93	18 Transcutaneous Passive Implant-Temporal Bone	0	0
69714		993	69727		0.000	14.45	7.13	18 Transcutaneous Passive Implant-Temporal Bone	0	0
New tech not currently reported		N/A	77089	See SOR for utilization estimate after Cat 1 code becomes active	N/A	0.00	0.20	19 Trabecular Bone Score (TBS)	0	0
New tech not currently reported		N/A	77090	See SOR for utilization estimate after Cat 1 code becomes active	N/A	0.00	0.00	19 Trabecular Bone Score (TBS)	0	0
New tech not currently reported		N/A	77091	See SOR for utilization estimate after Cat 1 code becomes active	N/A	0.00	0.00	19 Trabecular Bone Score (TBS)	0	0
New tech not currently reported		N/A	77092	See SOR for utilization estimate after Cat 1 code becomes active	N/A	0.00	0.20	19 Trabecular Bone Score (TBS)	0	0
80500	D	21,998	80503	21,998	1.000	0.37	0.50	20 Pathology Clinical Consult	10,999	8,139
80502	D	13,114	80504	10,491	0.800	1.33	0.91	20 Pathology Clinical Consult	9,547	13,953
80502	D	13,114	80505	2,622	0.200	1.33	1.80	20 Pathology Clinical Consult	4,720	3,487
80502	D	13,114	80506	262	0.020	0.00	0.80	20 Pathology Clinical Consult	210	0
91110		53,131	91110	53,131	1.000	2.49	2.24	21 Colon Capsule Endoscopy	119,013	132,296
91111		146	91111	146	1.000	1.00	1.00	21 Colon Capsule Endoscopy	146	146
0355T	D	-	91113	-	1.000	0.00	2.41	21 Colon Capsule Endoscopy	0	0
93653		31,821	93653	31,821	1.000	14.75	18.49	22 Cardiac Ablation Services Bundling	588,370	469,360

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
93613		80,773	Util Savings (Bundled into 93653)	27,172	0.336	5.23	0.00	22 Cardiac Ablation Services Bundling	0	142,110
93621		29,892	Util Savings (Bundled into 93653)	23,134	0.774	2.10	0.00	22 Cardiac Ablation Services Bundling	0	48,581
93654		7,750	93654	7,750	1.000	19.75	19.75	22 Cardiac Ablation Services Bundling	153,063	153,063
93655		31,147	93655	31,147	1.000	7.50	6.50	22 Cardiac Ablation Services Bundling	202,456	233,603
93656		53,327	93656	53,327	1.000	19.77	20.00	22 Cardiac Ablation Services Bundling	1,066,540	1,054,275
93613		80,773	Util Savings (Bundled into 93656)	49,327	0.611	5.23	0.00	22 Cardiac Ablation Services Bundling	0	257,980
93662		63,470	Util Savings (Bundled into 93656	48,277	0.761	2.80	0.00	22 Cardiac Ablation Services Bundling	0	135,176
93657		21,159	93657	21,159	1.000	7.50	6.50	22 Cardiac Ablation Services Bundling	137,534	158,693
93613		80,773	93613	4,274	0.053	5.23	5.23	22 Cardiac Ablation Services Bundling	22,353	22,353
93621		29,892	93621	6,758	0.226	2.10	2.10	22 Cardiac Ablation Services Bundling	14,192	14,192
93662		63,470	93662	15,193	0.239	1.44	1.44	22 Cardiac Ablation Services Bundling	21,878	21,878
G0424		15,482	94625	7,741	0.500	0.28	0.55	Outpatient Pulmonary Rehabilitation Services - Tab 23	4,258	2,167
G0424		15,482	94626	7,741	0.500	0.28	0.69	Outpatient Pulmonary Rehabilitation Services - Tab 23	5,341	2,167
New tech not currently reported			98975	-	N/A	0.00	0.00	Remote Therapeutic Monitoring - Tab 24	0	0
New tech not currently reported			98976	-	N/A	0.00	0.00	Remote Therapeutic Monitoring - Tab 24	0	0
New tech not currently reported			98977	-	N/A	0.00	0.00	Remote Therapeutic Monitoring - Tab 24	0	0
New tech not currently reported		-	98980	-	N/A	0.00	0.62	Remote Therapeutic Monitoring - Tab 24	0	0
New tech not currently reported		-	98981	-	N/A	0.00	0.61	Remote Therapeutic Monitoring - Tab 24	0	0
99490		4,188,228	99490	4,188,228	1.000	0.61	1.00	25 Principal Care Management and Chronic Care Mgmt	4,188,228	2,554,819
G2058	D	Created for 2020	99439	3,350,582	1.000	0.54	0.70	25 Principal Care Management and Chronic Care Mgmt	2,345,408	1,809,314
99491		48,091	99491	48,091	1.000	1.45	1.50	25 Principal Care Management and Chronic Care Mgmt	72,137	69,732
Bundled into '99491		48,091	99437	38,473	0.800	0.00	1.00	25 Principal Care Management and Chronic Care Mgmt	38,473	0
99487		264,419	99487	264,419	1.000	1.00	1.81	25 Principal Care Management and Chronic Care Mgmt	478,598	264,419
99489		211,330	99489	211,330	1.000	0.50	1.00	25 Principal Care Management and Chronic Care Mgmt	211,330	105,665
G2064	D	39,493	99424	39,493	1.000	1.45	1.45	25 Principal Care Management and Chronic Care Mgmt	57,265	57,265
Bundled into G2064	D	39,493	99425	9,873	0.250	0.00	1.00	25 Principal Care Management and Chronic Care Mgmt	9,873	0
G2065	D	238,853	99426	238,853	1.000	0.61	1.00	25 Principal Care Management and Chronic Care Mgmt	238,853	145,700
Bundled into G2065		238,853	99427	59,713	0.250	0.00	0.71	25 Principal Care Management and Chronic Care Mgmt	42,396	0
22867		2,131	22867	2,131	1.000	13.50	15.00	Insertion of Interlaminar/Interspinous Device - Tab 26	31,965	28,769
43850	D	5	Savings	5	1.000	27.58	0.00	Deletion of Codes with Low Utilization	0	138
43855	D	-	Savings	-	1.000	28.69	0.00	Deletion of Codes with Low Utilization	0	0
63194	D	1	Savings	1	1.000	22.10	0.00	Deletion of Codes with Low Utilization	0	22
63195	D	1	Savings	1	1.000	21.64	0.00	Deletion of Codes with Low Utilization	0	22
76101	D	2	Savings	2	1.000	0.58	0.00	Deletion of Codes with Low Utilization	0	1
76102	D	2,408	Savings	2,408	1.000	0.58	0.00	Deletion of Codes with Low Utilization	0	1,397
92559	D	-	Savings	-	1.000	0.00	0.00	Deletion of Codes with Low Utilization	0	0
92560	D	-	Savings	-	1.000	0.00	0.00	Deletion of Codes with Low Utilization	0	0

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
92561	D	345	Savings	345	1.000	0.00	0.00	Deletion of Codes with Low Utilization	0	0
92564	D	484	Savings	484	1.000	0.00	0.00	Deletion of Codes with Low Utilization	0	0
									24,451,116	22,160,780

Total Source Anesthesia Base Units		1,658,395
Total New/Revised Anesthesia Base Units		1,515,432
Base Units Difference		142,963
Anesthesia CF		21.5600
Anesthesia CF Redistribution	**$**	**3,082,282**

Total Source RVUs		25,683,413
Total New/Revised RVUs		27,958,326
RVU Difference		(2,274,913)
CF		34.8960
CF Redistribution	**$**	**(79,385,377)**

New Technology/New Services List

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
10011	Fine needle aspiration biopsy, including MR guidance; first lesion	Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		☐
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)	Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		☐
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Apr 2009	Adjacent Tissue Transfer	4	CPT 2010	October 2015	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	October 2023		☐
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr 2006	Fibroadenoma Cryoablation	11	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)	Oct 2016	Intraoperative Radiation Therapy Applicator Procedures	07	CPT 2018	October 2021		☐
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	October 2023		☐
20561	Needle insertion(s) without injection(s); 3 or more muscles	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	October 2023		☐
20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
20700	Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20701	Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20702	Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
20703	Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20704	Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20705	Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	October 2023		☐
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Apr 2014	Cryoablation Treatment of the Bone Tumors	04	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Resurvey for January 2012	☑
20986	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
20987	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21015	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21016	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21554	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21557	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21558	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21813	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21932	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21933	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21935	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21936	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	Apr 2014	Total Disc Arthroplasty Additional Cervical Level Add-On Code	07	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	January 2021	Survey April 2021	☐
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	January 2021	Survey April 2021	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22902	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22904	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22905	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23076	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23077	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23078	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23200	Radical resection of tumor; clavicle	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23210	Radical resection of tumor; scapula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23220	Radical resection of tumor, proximal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24073	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24077	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
24079	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24150	Radical resection of tumor, shaft or distal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24152	Radical resection of tumor, radial head or neck	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25077	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25078	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25170	Radical resection of tumor, radius or ulna	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26111	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26117	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26118	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26250	Radical resection of tumor, metacarpal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26260	Radical resection of tumor, proximal or middle phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26262	Radical resection of tumor, distal phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27048	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27049	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27059	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27077	Radical resection of tumor; innominate bone, total	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	Apr 2014	Sacroiliac Joint Fusion	08	CPT 2015	October 2018	Surveyed in April 2018 for a CMS Request in the Final Rule for 2018	☑
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Sep 2014	Sacroiliac Joint Fusion	06	CPT 2016	October 2019	Remove form list, was only identified with 27279 and that code has been resurveyed April 2018.	☑
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27328	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27329	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27365	Radical resection of tumor, femur or knee	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27615	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27616	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27645	Radical resection of tumor; tibia	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27646	Radical resection of tumor; fibula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27647	Radical resection of tumor; talus or calcaneus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28173	Radical resection of tumor; metatarsal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28175	Radical resection of tumor; phalanx of toe	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
29582	Code Deleted CPT 2018	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑
29583	Code Deleted CPT 2018	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2021	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Apr 2007	Arthroscopic Biceps Tenodesis	17	CPT 2008	September 2011	Resurvey for January 2012	☑
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
29916	Arthroscopy, hip, surgical; with labral repair	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	Feb 2009	Navigational Bronchoscopy	9	CPT 2010	October 2016	Review practice expense January 2014. Review data again in 3 years (Sept 2016).	☑
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	Feb 2010	Bronchoscopy with Balloon Occlusion	7	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	Jan 2012	Stereotactic Body Radiation	07	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	Jan 2017	Cryoablation of Pulmonary Tumors	08	CPT 2018	October 2021		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	Apr 2006	Percutaneous RF Pulmonary Tumor Ablation	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33271	Insertion of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33272	Removal of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed	Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	October 2022		☐
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	October 2022		☐
33286	Removal, subcutaneous cardiac rhythm monitor	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	October 2022		☐
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	October 2022		☐
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	Jan 2016	Closure Left Atrial Appendage with Endocardial Implant	10	CPT 2017	October 2022	Review in two years (October 2022); new FDA indication recently released, suggesting this service is still changing.	☐
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
33440	Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (Ross-Konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022		☐
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Jan 2015	Transcatheter Pulmonary Valve Implantation	06	CPT 2016	October 2022	Review in 3 years (Oct 2022); pediatric procedure with some CMS utilization.	☑
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	Apr 2007	Valve Sparing Aortic Annulus Reconstruction	24	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33866	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)	Oct 2018	Aortic Graft Procedures	06	CPT 2020	October 2023		☐
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	October 2021		☐
33928	Removal and replacement of total replacement heart system (artificial heart)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	October 2021		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	October 2021		☐
33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33949	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33951	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33952	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33953	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33954	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33955	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33957	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33958	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33959	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33962	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33963	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33964	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33965	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33966	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33969	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33984	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33985	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33986	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	Oct 2019	Percutaneous Ventricular Assist Device Insertion	05	CPT 2021	October 2024		☐
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	Oct 2019	Percutaneous Ventricular Assist Device Insertion	05	CPT 2021	October 2024		☐
33XX3		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	October 2025		☐
33XX4		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	October 2025		☐
33XX5		Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	October 2025		☐
33XXX		Jan 2021	Percutaneous Cerebral Embolic Protection	07	CPT 2022	October 2025		☐
34806	Code Deleted	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
35XX0		Jan 2021	Harvest of Upper Extremity Artery, Endoscopic and Open	09	CPT 2022	October 2025		☐
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		☐
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	October 2021	Review in October 2021 with the other codes in this family identified via the 2021 new technology/new services screen (36475-36479).	☐
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	October 2021	Review in October 2021 with the other codes in this family identified via the 2021 new technology/new services screen (36475-36479).	☐
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		☐
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		☐
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	Apr 2014	Transcatheter Placement of Carotid Stents	12	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
38220	Diagnostic bone marrow; aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		☐
38221	Diagnostic bone marrow; biopsy(ies)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		☐
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Apr 2010	Sentinel Lymph Node Mapping	8	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed	Jan 2014	Endoscopic Hypopharyngeal Diverticulotomy	7	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Apr 2015	Esophagogatric Fundoplasty Trans-Oral Approach	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	Apr 2008	Cholangioscopy-Pancreatoscopy	13	CPT 2009	September 2012	Specialty to survey Feb 2013 with family of services	☑
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	Apr 2008	Laparoscopic Heller Myotomy	12	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	October 2023	Review in 3 years (October 2023). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐
43285	Removal of esophageal sphincter augmentation device	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	October 2023	Review in 3 years (October 2023). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐
434XX		Oct 2020	Per-Oral Endoscopic Myotomy (POEM)	07	CPT 2022	October 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Apr 2009	Laparoscopic Longitudinal Gastrectomy	14	CPT 2010	September 2013	Remove from list, carrier priced.	☑
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Apr 2012	Fecal Bacteriotherapy	18	CPT 2013	October 2018	The specialty societies indicated that they tried to develop a category I code to replace 44705 which is not currently covered by Medicare, but the CPT Editorial Panel did not accept the coding change proposal due to a lack in literature provided. The Workgroup recommended that these services be reviewed in 2 year after additional utilization data is available (October 2018). In Octobre 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	Apr 2014	High Resolution Anoscopy	14	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	Apr 2014	High Resolution Anoscopy	14	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2021).	☐
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	Apr 2009	Fistula Plug	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	Oct 2018	Transanal Hemorrhoidal Dearterialization	07	CPT 2020	October 2023		☐
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Apr 2014	Cryoablation of Liver Tumor	15	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr 2007	Percutaneous Renal Tumor Cryotherapy	A	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
50606	Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50705	Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50706	Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	☑
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	☑
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	Jan 2018	Transurethral Destruction of Prostate Tissue	13	CPT 2019	October 2022		☐
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Feb 2009	Temporary Prostatic Urethral Stent Insertion	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Apr 2010	Transurethral Radiofrequency Bladder Neck and Urethra	12	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Apr 2008	Saturation Biopsies	15	CPT 2009	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Oct 2009	Laparoscopic Radical Prostatectomy	14	CPT 2011	September 2014	Survey for April 2015. Specialty society should consider surveying 55845 and 55866 at the same time.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	Jan 2017	Peri-Prostatic Implantation of Biodegradable Material	13	CPT 2018	October 2021		☐
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	Oct 2019	Transrectal High Intesity Focused US Prostate Ablation	06	CPT 2021	October 2024		☐
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr 2007	Laparoscopic Paravaginal Defect Repair	C	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
57465	Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)	Jan 2020	Computer-Aided Mapping of Cervix Uteri	14	CPT 2021	October 2024		☐
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Jan 2016	Laparoscopic Radiofrequency Ablation of Uterine Fibroids	18	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
61651	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑
617X1		Jan 2021	Intracranial Laser Interstitial Thermal Therapy (LITT)	12	CPT 2022	October 2025		☐
617X2		Jan 2021	Intracranial Laser Interstitial Thermal Therapy (LITT)	12	CPT 2022	October 2025		☐
62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	October 2023		☐
62329	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	October 2023		☐
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	Jan 2016	Endoscopic Decompression of Spinal Cord Nerve	19	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan 2019	Radiofrequency Neurotomy Sacroiliac Joint	08	CPT 2020	October 2023		☐
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	Jan 2019	Genicular Injection and RFA	10	CPT 2020	October 2023		☐
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Apr 2010	Posterior Tibial Nerve Stimulation	13	CPT 2011	October 2019	Surveyed for April 2015, RUC recommended to review utilization again in 2 years (Oct 2019). In Oct 2019, recommended to remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	Jan 2019	Genicular Injection and RFA	10	CPT 2020	October 2023		☐
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan 2019	Radiofrequency Neurotomy Sacroiliac Joint	08	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	October 2023		☐
646X0		Jan 2021	Destruction of Intraosseous Basivertebral Nerve	14	CPT 2022	October 2025		☐
646X1		Jan 2021	Destruction of Intraosseous Basivertebral Nerve	14	CPT 2022	October 2025		☐
65756	Keratoplasty (corneal transplant); endothelial	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated. Though volume grew faster than expected, there was a decrease in other services of similar magnitude, that were previously reported and had similar work RVUs. All remained work neutral.	☑
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated.	☑
65778	Placement of amniotic membrane on the ocular surface; without sutures	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	☑
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	☑
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	Oct 2011	Relativity Assessment Workgroup	51	CPT 2011	September 2014	Survey for April 2015.	☑
65785	Implantation of intrastromal corneal ring segments	Jan 2015	Intrastomal Corneal Ring Implantation	11	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Jan 2020 - Referred to CPT	☑
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Jan 2020 - Referred to CPT	☑
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	Apr 2013	Insertion of Anterior Segment	14	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
66982		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	October 2025		☐
66984		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	October 2025		☐
66987		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	October 2025		☐
66988		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	October 2025		☐
669X1		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	October 2025		☐
669X2		Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	October 2025		☐
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr 2007	Nasolacrimal Duct Balloon Catheter Dilation	E	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
68XXX		Jan 2021	Lacrimal Canaliculus Drug Eluting Implant Insertion	17	CPT 2022	October 2025		☐
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	October 2024		☐
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	October 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	Oct 2019	Screening CT of Thorax	07	CPT 2021	October 2024		☐
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558.	☑
75558	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
75560	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75560.	☑
75562	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
75564	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
76391	Magnetic resonance (eg, vibration) elastography	Jan 2018	Magnetic Resonance Elastography	16	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation	Apr 2010	Ultrasound of Extremity	17	CPT 2011	October 2021	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019). In Oct 2019, the RAW recommended to review in 2 years (Oct 2021) after additional utilization data is available.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation	Apr 2010	Ultrasound of Extremity	17	CPT 2011	October 2021	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019). In Oct 2019, the RAW recommended to review in 2 years (Oct 2021) after additional utilization data is available.	☐
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76979	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	October 2022		☐
76981	Ultrasound, elastography; parenchyma (eg, organ)	Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		☐
76982	Ultrasound, elastography; first target lesion	Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		☐
76983	Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		☐
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		☐
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		☐
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		☐
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		☐
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77061	Diagnostic digital breast tomosynthesis; unilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	☐
77062	Diagnostic digital breast tomosynthesis; bilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	☐
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	☐
77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)	Jan 2013	Respiratory Motion Management Simulation	14	CPT 2014	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Practice expense review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Feb 2011	Stereotactic Body Radiation Delivery	32	CPT 2012	October 2015	Practice expense review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Survey (work) and PE review (Feb 2011).	☑
77520	Proton treatment delivery; simple, without compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	October 2024		☐
77522	Proton treatment delivery; simple, with compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	October 2024		☐
77523	Proton treatment delivery; intermediate	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	October 2024		☐
77525	Proton treatment delivery; complex	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	October 2024		☐
77X01		Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	October 2025		☐
77X02		Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	October 2025		☐
77X03		Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	October 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77X04		Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	October 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting parathyroid	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							scintigraphy as an effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be postponed and	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							reviewed in 2 years after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting parathyroid	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							scintigraphy as an effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be postponed and	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							reviewed in 2 years after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78491	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78492	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)	Jan 2019	Myocardial PET	13	CPT 2020	October 2023		☐
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78813	Positron emission tomography (PET) imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging	Jan 2019	SPECT-CT Procedures	14	CPT 2020	October 2023		☐
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Jan 2019	SPECT-CT Procedures	14	CPT 2020	October 2023		☐
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Jan 2019	SPECT-CT Procedures	14	CPT 2020	October 2023		☐
78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	Jan 2019	SPECT-CT Procedures	14	CPT 2020	October 2023		☐
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Oct 2012	Molecular Pathology -Tier 1	11	CPT 2014	October 2017	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81243	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81244	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G>A, c.173+1000C>T)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1 (eg, verification typing)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant AGTR1 (angiotensin II receptor, type 1) (eg, essential hypertension), 1166A>C variant BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type 1A), Y438N variant CCR5 (chemokine C-C motif receptor 5) (eg, HIV resistance), 32-bp deletion mutation/794 825del32 deletion CLRN1 (clarin 1) (eg, Usher syndrome, type 3), N48K variant F2 (coagulation factor 2) (eg, hereditary hypercoagulability), 1199G>A variant F5 (coagulation factor V) (eg, hereditary hypercoagulability), HR2 variant F7 (coagulation factor VII [serum prothrombin conversion accelerator]) (eg, hereditary hypercoagulability), R353Q variant F13B (coagulation factor XIII, B polypeptide) (eg, hereditary hypercoagulability), V34L variant FGB (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455G>A variant FGFR1 (fibroblast growth factor receptor 1) (eg, Pfeiffer syndrome type 1, craniosynostosis), P252R variant FGFR3 (fibroblast growth factor receptor 3) (eg, Muenke syndrome), P250R variant FKTN (fukutin) (eg, Fukuyama congenital muscular dystrophy), retrotransposon insertion variant GNE (glucosamine [UDP-N-acetyl]-2-epimerase/N-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [IBM2], Nonaka myopathy), M712T variant IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), A282V variant LCT (lactase-phlorizin hydrolase) (eg, lactose intolerance), 13910 C>T variant NEB (nebulin) (eg, nemaline myopathy 2), exon 55 deletion variant PCDH15	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(protocadherin-related 15) (eg, Usher syndrome type 1F), R245X variant SERPINE1 (serpine peptidase inhibitor clade E, member 1, plasminogen activator inhibitor -1, PAI-1) (eg, thrombophilia), 4G variant SHOC2 (soc-2 suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), S2G variant SRY (sex determining region Y) (eg, 46,XX testicular disorder of sex development, gonadal dysgenesis), gene analysis TOR1A (torsin family 1, member A [torsin A]) (eg, early-onset primary dystonia [DYT1]), 907_909delGAG (904_906delGAG) variant							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), common variants (eg, c.3898-9G>A [c.3992-9G>A], F1388del) ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib resistance), T315I variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, K304E, Y42H) ADRB2 (adrenergic beta-2 receptor surface) (eg, drug metabolism), common variants (eg, G16R, Q27E) APOB (apolipoprotein B) (eg, familial hypercholesterolemia type B), common variants (eg, R3500Q, R3500W) APOE (apolipoprotein E) (eg, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (eg, *2, *3, *4) CBFB/MYH11 (inv(16)) (eg, acute myeloid leukemia), qualitative, and quantitative, if performed CBS (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), common variants (eg, I278T, G307S) CFH/ARMS2 (complement factor H/age-related maculopathy susceptibility 2) (eg, macular degeneration), common variants (eg, Y402H [CFH], A69S [ARMS2]) DEK/NUP214 (t(6;9)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed E2A/PBX1 (t(1;19)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed EML4/ALK (inv(2)) (eg, non-small cell lung cancer), translocation or inversion analysis ETV6/RUNX1 (t(12;21)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed EWSR1/ATF1 (t(12;22)) (eg, clear cell sarcoma), translocation analysis, qualitative, and quantitative, if performed EWSR1/ERG (t(21;22))	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(eg, Ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and quantitative, if performed EWSR1/FLI1 (t(11;22)) (eg, Ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and quantitative, if performed EWSR1/WT1 (t(11;22)) (eg, desmoplastic small round cell tumor), translocation analysis, qualitative, and quantitative, if performed F11 (coagulation factor XI) (eg, coagulation disorder), common variants (eg, E117X [Type II], F283L [Type III], IVS14del14, and IVS14+1G>A [Type I]) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), common variants (eg, 1138G>A, 1138G>C, 1620C>A, 1620C>G) FIP1L1/PDGFRA (del[4q12]) (eg, imatinib-sensitive chronic eosinophilic leukemia), qualitative, and quantitative, if performed FLG (filaggrin) (eg, ichthyosis vulgaris), common variants (eg, R501X, 2282del4, R2447X, S3247X, 3702delG) FOXO1/PAX3 (t(2;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed FOXO1/PAX7 (t(1;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed FUS/DDIT3 (t(12;16)) (eg, myxoid liposarcoma), translocation analysis, qualitative, and quantitative, if performed GALC (galactosylceramidase) (eg, Krabbe disease), common variants (eg, c.857G>A, 30-kb deletion) GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), common variants (eg, Q188R, S135L, K285N, T138M, L195P, Y209C, IVS2-2A>G, P171S, del5kb, N314D, L218L/N314D) H19 (imprinted maternally expressed transcript [non-protein coding]) (eg, Beckwith-Wiedemann syndrome), methylation analysis IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma), translocation analysis; single breakpoint (eg, major breakpoint region [MBR] or minor cluster region [mcr]), qualitative or quantitative (When both MBR and mcr breakpoints are performed, use 81278)							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	KCNQ1OT1 (KCNQ1 overlapping transcript 1 [non-protein coding]) (eg, Beckwith-Wiedemann syndrome), methylation analysis LINC00518 (long intergenic non-protein coding RNA 518) (eg, melanoma), expression analysis LRRK2 (leucine-rich repeat kinase 2) (eg, Parkinson disease), common variants (eg, R1441G, G2019S, I2020T) MED12 (mediator complex subunit 12) (eg, FG syndrome type 1, Lujan syndrome), common variants (eg, R961W, N1007S) MEG3/DLK1 (maternally expressed 3 [non-protein coding]/delta-like 1 homolog [Drosophila]) (eg, intrauterine growth retardation), methylation analysis MLL/AFF1 (t(4;11)) (eg, acute lymphoblastic leukemia), translocation analysis, qualitative, and quantitative, if performed MLL/MLLT3 (t(9;11)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed MT-ATP6 (mitochondrially encoded ATP synthase 6) (eg, neuropathy with ataxia and retinitis pigmentosa [NARP], Leigh syndrome), common variants (eg, m.8993T>G, m.8993T>C) MT-ND4, MT-ND6 (mitochondrially encoded NADH dehydrogenase 4, mitochondrially encoded NADH dehydrogenase 6) (eg, Leber hereditary optic neuropathy [LHON]), common variants (eg, m.11778G>A, m.3460G>A, m.14484T>C) MT-ND5 (mitochondrially encoded tRNA leucine 1 [UUA/G], mitochondrially encoded NADH dehydrogenase 5) (eg, mitochondrial encephalopathy with lactic acidosis and stroke-like episodes [MELAS]), common variants (eg, m.3243A>G, m.3271T>C, m.3252A>G, m.13513G>A) MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), common variants (eg, m.1555A>G, m.1494C>T) MT-TK (mitochondrially encoded tRNA lysine) (eg, myoclonic epilepsy with ragged-red fibers [MERRF]), common variants (eg, m.8344A>G, m.8356T>C) MT-TL1 (mitochondrially encoded tRNA leucine 1 [UUA/G]) (eg, diabetes and hearing loss), common variants (eg, m.3243A>G, m.14709							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	T>C) MT-TL1 MT-TS1, MT-RNR1 (mitochondrially encoded tRNA serine 1 [UCN], mitochondrially encoded 12S RNA) (eg, nonsyndromic sensorineural deafness [including aminoglycoside-induced nonsyndromic deafness]), common variants (eg, m.7445A>G, m.1555A>G) MUTYH (mutY homolog [E. coli]) (eg, MYH-associated polyposis), common variants (eg, Y165C, G382D) NOD2 (nucleotide-binding oligomerization domain containing 2) (eg, Crohn's disease, Blau syndrome), common variants (eg, SNP 8, SNP 12, SNP 13) NPM1/ALK (t(2;5)) (eg, anaplastic large cell lymphoma), translocation analysis PAX8/PPARG (t(2;3) (q13;p25)) (eg, follicular thyroid carcinoma), translocation analysis PRAME (preferentially expressed antigen in melanoma) (eg, melanoma), expression analysis PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), common variants (eg, N29I, A16V, R122H) PYGM (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type V, McArdle disease), common variants (eg, R50X, G205S) RUNX1/RUNX1T1 (t(8;21)) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed SS18/SSX1 (t(X;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed SS18/SSX2 (t(X;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), common variants (eg, T791M, R816W, R854Q)							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD]) Chromosome 1p-/19q- (eg, glial tumors), deletion analysis Chromosome 18q- (eg, D18S55, D18S58, D18S61, D18S64, and D18S69) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity) COL1A1/PDGFB (t(17;22)) (eg, dermatofibrosarcoma protuberans), translocation analysis, multiple breakpoints, qualitative, and quantitative, if performed CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide 2) (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, IVS2-13G, P30L, I172N, exon 6 mutation cluster [I235N, V236E, M238K], V281L, L307FfsX6, Q318X, R356W, P453S, G110VfsX21, 30-kb deletion variant) ESR1/PGR (receptor 1/progesterone receptor) ratio (eg, breast cancer) MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants (eg, E148Q, P369S, F479L, M680I, I692del, M694V, M694I, K695R, V726A, A744S, R761H) TRD@ (T cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population Uniparental disomy (UPD) (eg, Russell-Silver syndrome, Prader-Willi/Angelman syndrome), short tandem repeat (STR) analysis	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ANG (angiogenin, ribonuclease, RNase A family, 5) (eg, amyotrophic lateral sclerosis), full gene sequence ARX (aristaless-related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), duplication/deletion analysis CEL (carboxyl ester lipase [bile salt-stimulated lipase]) (eg, maturity-onset diabetes of the young [MODY]), targeted sequence analysis of exon 11 (eg, c.1785delC, c.1686delT) CTNNB1 (catenin [cadherin-associated protein], beta 1, 88kDa) (eg, desmoid tumors), targeted sequence analysis (eg, exon 3) DAZ/SRY (deleted in azoospermia and sex determining region Y) (eg, male infertility), common deletions (eg, AZFa, AZFb, AZFc, AZFd) DNMT3A (DNA [cytosine-5-]-methyltransferase 3 alpha) (eg, acute myeloid leukemia), targeted sequence analysis (eg, exon 23) EPCAM (epithelial cell adhesion molecule) (eg, Lynch syndrome), duplication/deletion analysis F8 (coagulation factor VIII) (eg, hemophilia A), inversion analysis, intron 1 and intron 22A F12 (coagulation factor XII [Hageman factor]) (eg, angioedema, hereditary, type III; factor XII deficiency), targeted sequence analysis of exon 9 FGFR3 (fibroblast growth factor receptor 3) (eg, isolated craniosynostosis), targeted sequence analysis (eg, exon 7) (For targeted sequence analysis of multiple FGFR3 exons, use 81404) GJB1 (gap junction protein, beta 1) (eg, Charcot-Marie-Tooth X-linked), full gene sequence GNAQ (guanine nucleotide-binding protein G[q] subunit alpha) (eg, uveal melanoma), common variants (eg, R183, Q209) Human erythrocyte antigen gene analyses (eg, SLC14A1 [Kidd blood group], BCAM [Lutheran blood group], ICAM4 [Landsteiner-Wiener blood	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	group], SLC4A1 [Diego blood group], AQP1 [Colton blood group], ERMAP [Scianna blood group], RHCE [Rh blood group, CcEe antigens], KEL [Kell blood group], DARC [Duffy blood group], GYPA, GYPB, GYPE [MNS blood group], ART4 [Dombrock blood group]) (eg, sickle-cell disease, thalassemia, hemolytic transfusion reactions, hemolytic disease of the fetus or newborn), common variants HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), exon 2 sequence KCNC3 (potassium voltage-gated channel, Shaw-related subfamily, member 3) (eg, spinocerebellar ataxia), targeted sequence analysis (eg, exon 2) KCNJ2 (potassium inwardly-rectifying channel, subfamily J, member 2) (eg, Andersen-Tawil syndrome), full gene sequence KCNJ11 (potassium inwardly-rectifying channel, subfamily J, member 11) (eg, familial hyperinsulinism), full gene sequence Killer cell immunoglobulin-like receptor (KIR) gene family (eg, hematopoietic stem cell transplantation), genotyping of KIR family genes Known familial variant not otherwise specified, for gene listed in Tier 1 or Tier 2, or identified during a genomic sequencing procedure, DNA sequence analysis, each variant exon (For a known familial variant that is considered a common variant, use specific common variant Tier 1 or Tier 2 code) MC4R (melanocortin 4 receptor) (eg, obesity), full gene sequence MICA (MHC class I polypeptide-related sequence A) (eg, solid organ transplantation), common variants (eg, *001, *002) MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), full gene sequence MT-TS1 (mitochondrially encoded tRNA serine 1) (eg, nonsyndromic hearing loss), full gene sequence NDP (Norrie disease [pseudoglioma]) (eg, Norrie disease), duplication/deletion analysis NHLRC1 (NHL repeat containing 1) (eg, progressive myoclonus epilepsy), full gene sequence PHOX2B (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), duplication/deletion							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	analysis PLN (phospholamban) (eg, dilated cardiomyopathy, hypertrophic cardiomyopathy), full gene sequence RHD (Rh blood group, D antigen) (eg, hemolytic disease of the fetus and newborn, Rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene) RHD (Rh blood group, D antigen) (eg, hemolytic disease of the fetus and newborn, Rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene), performed on cell-free fetal DNA in maternal blood (For human erythrocyte gene analysis of RHD, use a separate unit of 81403) SH2D1A (SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), duplication/deletion analysis TWIST1 (twist homolog 1 [Drosophila]) (eg, Saethre-Chotzen syndrome), duplication/deletion analysis UBA1 (ubiquitin-like modifier activating enzyme 1) (eg, spinal muscular atrophy, X-linked), targeted sequence analysis (eg, exon 15) VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), deletion/duplication analysis VWF (von Willebrand factor) (eg, von Willebrand disease types 2A, 2B, 2M), targeted sequence analysis (eg, exon 28)							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), targeted sequence analysis (eg, exons 5 and 6) AQP2 (aquaporin 2 [collecting duct]) (eg, nephrogenic diabetes insipidus), full gene sequence ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), full gene sequence AVPR2 (arginine vasopressin receptor 2) (eg, nephrogenic diabetes insipidus), full gene sequence BBS10 (Bardet-Biedl syndrome 10) (eg, Bardet-Biedl syndrome), full gene sequence BTD (biotinidase) (eg, biotinidase deficiency), full gene sequence C10orf2 (chromosome 10 open reading frame 2) (eg, mitochondrial DNA depletion syndrome), full gene sequence CAV3 (caveolin 3) (eg, CAV3-related distal myopathy, limb-girdle muscular dystrophy type 1C), full gene sequence CD40LG (CD40 ligand) (eg, X-linked hyper IgM syndrome), full gene sequence CDKN2A (cyclin-dependent kinase inhibitor 2A) (eg, CDKN2A-related cutaneous malignant melanoma, familial atypical mole-malignant melanoma syndrome), full gene sequence CLRN1 (clarin 1) (eg, Usher syndrome, type 3), full gene sequence COX6B1 (cytochrome c oxidase subunit VIb polypeptide 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence CPT2 (carnitine palmitoyltransferase 2) (eg, carnitine palmitoyltransferase II deficiency), full gene sequence CRX (cone-rod homeobox) (eg, cone-rod dystrophy 2, Leber congenital amaurosis), full gene sequence CYP1B1 (cytochrome P450, family 1, subfamily B, polypeptide 1) (eg, primary congenital glaucoma), full gene sequence EGR2 (early growth response 2) (eg, Charcot-Marie-	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	Tooth), full gene sequence EMD (emerin) (eg, Emery-Dreifuss muscular dystrophy), duplication/deletion analysis EPM2A (epilepsy, progressive myoclonus type 2A, Lafora disease [laforin]) (eg, progressive myoclonus epilepsy), full gene sequence FGF23 (fibroblast growth factor 23) (eg, hypophosphatemic rickets), full gene sequence FGFR2 (fibroblast growth factor receptor 2) (eg, craniosynostosis, Apert syndrome, Crouzon syndrome), targeted sequence analysis (eg, exons 8, 10) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), targeted sequence analysis (eg, exons 8, 11, 12, 13) FHL1 (four and a half LIM domains 1) (eg, Emery-Dreifuss muscular dystrophy), full gene sequence FKRP (fukutin related protein) (eg, congenital muscular dystrophy type 1C [MDC1C], limb-girdle muscular dystrophy [LGMD] type 2I), full gene sequence FOXG1 (forkhead box G1) (eg, Rett syndrome), full gene sequence FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), characterization of haplotype(s) (ie, chromosome 4A and 4B haplotypes) GH1 (growth hormone 1) (eg, growth hormone deficiency), full gene sequence GP1BB (glycoprotein Ib [platelet], beta polypeptide) (eg, Bernard-Soulier syndrome type B), full gene sequence (For common deletion variants of alpha globin 1 and alpha globin 2 genes, use 81257) HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), duplication/deletion analysis HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), full gene sequence HSD3B2 (hydroxy-delta-5-steroid dehydrogenase, 3 beta- and steroid delta-isomerase 2) (eg, 3-beta-hydroxysteroid dehydrogenase type II deficiency), full gene sequence HSD11B2 (hydroxysteroid [11-beta]							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	dehydrogenase 2) (eg, mineralocorticoid excess syndrome), full gene sequence HSPB1 (heat shock 27kDa protein 1) (eg, Charcot-Marie-Tooth disease), full gene sequence INS (insulin) (eg, diabetes mellitus), full gene sequence KCNJ1 (potassium inwardly-rectifying channel, subfamily J, member 1) (eg, Bartter syndrome), full gene sequence KCNJ10 (potassium inwardly-rectifying channel, subfamily J, member 10) (eg, SeSAME syndrome, EAST syndrome, sensorineural hearing loss), full gene sequence LITAF (lipopolysaccharide-induced TNF factor) (eg, Charcot-Marie-Tooth), full gene sequence MEFV (Mediterranean fever) (eg, familial Mediterranean fever), full gene sequence MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), duplication/deletion analysis MMACHC (methylmalonic aciduria [cobalamin deficiency] cblC type, with homocystinuria) (eg, methylmalonic acidemia and homocystinuria), full gene sequence MPV17 (MpV17 mitochondrial inner membrane protein) (eg, mitochondrial DNA depletion syndrome), duplication/deletion analysis NDP (Norrie disease [pseudoglioma]) (eg, Norrie disease), full gene sequence NDUFA1 (NADH dehydrogenase [ubiquinone] 1 alpha subcomplex, 1, 7.5kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFAF2 (NADH dehydrogenase [ubiquinone] 1 alpha subcomplex, assembly factor 2) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFS4 (NADH dehydrogenase [ubiquinone] Fe-S protein 4, 18kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NIPA1 (non-imprinted in Prader-Willi/Angelman syndrome 1) (eg, spastic paraplegia), full gene sequence NLGN4X (neuroligin 4, X-linked) (eg, autism spectrum disorders), duplication/deletion analysis NPC2 (Niemann-Pick disease, type C2 [epididymal secretory protein E1]) (eg, Niemann-Pick disease							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	type C2), full gene sequence NR0B1 (nuclear receptor subfamily 0, group B, member 1) (eg, congenital adrenal hypoplasia), full gene sequence PDX1 (pancreatic and duodenal homeobox 1) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence PHOX2B (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), full gene sequence PLP1 (proteolipid protein 1) (eg, Pelizaeus-Merzbacher disease, spastic paraplegia), duplication/deletion analysis PQBP1 (polyglutamine binding protein 1) (eg, Renpenning syndrome), duplication/deletion analysis PRNP (prion protein) (eg, genetic prion disease), full gene sequence PROP1 (PROP paired-like homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence PRPH2 (peripherin 2 [retinal degeneration, slow]) (eg, retinitis pigmentosa), full gene sequence PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), targeted sequence analysis (eg, exons 7, 12, 14, 17) RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2B and familial medullary thyroid carcinoma), common variants (eg, M918T, 2647_2648delinsTT, A883F) RHO (rhodopsin) (eg, retinitis pigmentosa), full gene sequence RP1 (retinitis pigmentosa 1) (eg, retinitis pigmentosa), full gene sequence SCN1B (sodium channel, voltage-gated, type I, beta) (eg, Brugada syndrome), full gene sequence SCO2 (SCO cytochrome oxidase deficient homolog 2 [SCO1L]) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), duplication/deletion analysis SDHD (succinate dehydrogenase complex, subunit D, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence SGCG							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), duplication/deletion analysis SH2D1A (SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, Allan-Herndon-Dudley syndrome), duplication/deletion analysis SLC25A20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), duplication/deletion analysis SLC25A4 (solute carrier family 25 [mitochondrial carrier; adenine nucleotide translocator], member 4) (eg, progressive external ophthalmoplegia), full gene sequence SOD1 (superoxide dismutase 1, soluble) (eg, amyotrophic lateral sclerosis), full gene sequence SPINK1 (serine peptidase inhibitor, Kazal type 1) (eg, hereditary pancreatitis), full gene sequence STK11 (serine/threonine kinase 11) (eg, Peutz-Jeghers syndrome), duplication/deletion analysis TACO1 (translational activator of mitochondrial encoded cytochrome c oxidase I) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence THAP1 (THAP domain containing, apoptosis associated protein 1) (eg, torsion dystonia), full gene sequence TOR1A (torsin family 1, member A [torsin A]) (eg, torsion dystonia), full gene sequence TTPA (tocopherol [alpha] transfer protein) (eg, ataxia), full gene sequence TTR (transthyretin) (eg, familial transthyretin amyloidosis), full gene sequence TWIST1 (twist homolog 1 [Drosophila]) (eg, Saethre-Chotzen syndrome), full gene sequence TYR (tyrosinase [oculocutaneous albinism IA]) (eg, oculocutaneous albinism IA), full gene sequence UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, hereditary unconjugated hyperbilirubinemia [Crigler-Najjar syndrome]) full gene sequence USH1G (Usher							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	syndrome 1G [autosomal recessive]) (eg, Usher syndrome, type 1), full gene sequence VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 1C), targeted sequence analysis (eg, exons 26, 27, 37) ZEB2 (zinc finger E-box binding homeobox 2) (eg, Mowat-Wilson syndrome), duplication/deletion analysis ZNF41 (zinc finger protein 41) (eg, X-linked mental retardation 89), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis) ABCD1 (ATP-binding cassette, sub-family D [ALD], member 1) (eg, adrenoleukodystrophy), full gene sequence ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), full gene sequence ACTA2 (actin, alpha 2, smooth muscle, aorta) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence ACTC1 (actin, alpha, cardiac muscle 1) (eg, familial hypertrophic cardiomyopathy), full gene sequence ANKRD1 (ankyrin repeat domain 1) (eg, dilated cardiomyopathy), full gene sequence APTX (aprataxin) (eg, ataxia with oculomotor apraxia 1), full gene sequence ARSA (arylsulfatase A) (eg, arylsulfatase A deficiency), full gene sequence BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type 1A), full gene sequence BCS1L (BCS1-like [S. cerevisiae]) (eg, Leigh syndrome, mitochondrial complex III deficiency, GRACILE syndrome), full gene sequence BMPR2 (bone morphogenetic protein receptor, type II [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), duplication/deletion analysis CASQ2 (calsequestrin 2 [cardiac muscle]) (eg, catecholaminergic polymorphic ventricular tachycardia), full gene sequence CASR (calcium-sensing receptor) (eg, hypocalcemia), full gene sequence CDKL5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), duplication/deletion analysis CHRNA4 (cholinergic receptor, nicotinic, alpha 4) (eg, nocturnal frontal lobe epilepsy), full gene sequence CHRNB2 (cholinergic receptor, nicotinic, beta 2 [neuronal]) (eg, nocturnal frontal lobe epilepsy), full gene sequence COX10 (COX10 homolog, cytochrome c oxidase	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	assembly protein) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence COX15 (COX15 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence CPOX (coproporphyrinogen oxidase) (eg, hereditary coproporphyria), full gene sequence CTRC (chymotrypsin C) (eg, hereditary pancreatitis), full gene sequence CYP11B1 (cytochrome P450, family 11, subfamily B, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence CYP17A1 (cytochrome P450, family 17, subfamily A, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide2) (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence Cytogenomic constitutional targeted microarray analysis of chromosome 22q13 by interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities (When performing genome-wide cytogenomic constitutional microarray analysis, see 81228, 81229) (Do not report analyte-specific molecular pathology procedures separately when the specific analytes are included as part of the microarray analysis of chromosome 22q13) (Do not report 88271 when performing cytogenomic microarray analysis) DBT (dihydrolipoamide branched chain transacylase E2) (eg, maple syrup urine disease, type 2), duplication/deletion analysis DCX (doublecortin) (eg, X-linked lissencephaly), full gene sequence DES (desmin) (eg, myofibrillar myopathy), full gene sequence DFNB59 (deafness, autosomal recessive 59) (eg, autosomal recessive nonsyndromic hearing impairment), full gene sequence DGUOK (deoxyguanosine kinase) (eg, hepatocerebral mitochondrial DNA depletion syndrome), full gene sequence DHCR7 (7-dehydrocholesterol reductase) (eg, Smith-Lemli-Opitz syndrome), full							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	gene sequence EIF2B2 (eukaryotic translation initiation factor 2B, subunit 2 beta, 39kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EMD (emerin) (eg, Emery-Dreifuss muscular dystrophy), full gene sequence ENG (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), duplication/deletion analysis EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), duplication/deletion analysis FGFR1 (fibroblast growth factor receptor 1) (eg, Kallmann syndrome 2), full gene sequence FH (fumarate hydratase) (eg, fumarate hydratase deficiency, hereditary leiomyomatosis with renal cell cancer), full gene sequence FKTN (fukutin) (eg, limb-girdle muscular dystrophy [LGMD] type 2M or 2L), full gene sequence FTSJ1 (FtsJ RNA methyltransferase homolog 1 [E. coli]) (eg, X-linked mental retardation 9), duplication/deletion analysis GABRG2 (gamma-aminobutyric acid [GABA] A receptor, gamma 2) (eg, generalized epilepsy with febrile seizures), full gene sequence GCH1 (GTP cyclohydrolase 1) (eg, autosomal dominant dopa-responsive dystonia), full gene sequence GDAP1 (ganglioside-induced differentiation-associated protein 1) (eg, Charcot-Marie-Tooth disease), full gene sequence GFAP (glial fibrillary acidic protein) (eg, Alexander disease), full gene sequence GHR (growth hormone receptor) (eg, Laron syndrome), full gene sequence GHRHR (growth hormone releasing hormone receptor) (eg, growth hormone deficiency), full gene sequence GLA (galactosidase, alpha) (eg, Fabry disease), full gene sequence HNF1A (HNF1 homeobox A) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HTRA1 (HtrA serine peptidase 1) (eg, macular degeneration), full gene sequence IDS (iduronate 2-sulfatase) (eg, mucopolysacchridosis, type II), full gene sequence IL2RG (interleukin 2 receptor, gamma)							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(eg, X-linked severe combined immunodeficiency), full gene sequence ISPD (isoprenoid synthase domain containing) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, Noonan syndrome), full gene sequence LAMP2 (lysosomal-associated membrane protein 2) (eg, Danon disease), full gene sequence LDLR (low density lipoprotein receptor) (eg, familial hypercholesterolemia), duplication/deletion analysis MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), full gene sequence MMAA (methylmalonic aciduria [cobalamine deficiency] type A) (eg, MMAA-related methylmalonic acidemia), full gene sequence MMAB (methylmalonic aciduria [cobalamine deficiency] type B) (eg, MMAA-related methylmalonic acidemia), full gene sequence MPI (mannose phosphate isomerase) (eg, congenital disorder of glycosylation 1b), full gene sequence MPV17 (MpV17 mitochondrial inner membrane protein) (eg, mitochondrial DNA depletion syndrome), full gene sequence MPZ (myelin protein zero) (eg, Charcot-Marie-Tooth), full gene sequence MTM1 (myotubularin 1) (eg, X-linked centronuclear myopathy), duplication/deletion analysis MYL2 (myosin, light chain 2, regulatory, cardiac, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYL3 (myosin, light chain 3, alkali, ventricular, skeletal, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYOT (myotilin) (eg, limb-girdle muscular dystrophy), full gene sequence NDUFS7 (NADH dehydrogenase [ubiquinone] Fe-S protein 7, 20kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFS8 (NADH dehydrogenase [ubiquinone] Fe-S protein 8, 23kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFV1 (NADH							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	dehydrogenase [ubiquinone] flavoprotein 1, 51kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NEFL (neurofilament, light polypeptide) (eg, Charcot-Marie-Tooth), full gene sequence NF2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), duplication/deletion analysis NLGN3 (neuroligin 3) (eg, autism spectrum disorders), full gene sequence NLGN4X (neuroligin 4, X-linked) (eg, autism spectrum disorders), full gene sequence NPHP1 (nephronophthisis 1 [juvenile]) (eg, Joubert syndrome), deletion analysis, and duplication analysis, if performed NPHS2 (nephrosis 2, idiopathic, steroid-resistant [podocin]) (eg, steroid-resistant nephrotic syndrome), full gene sequence NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), duplication/deletion analysis OTC (ornithine carbamoyltransferase) (eg, ornithine transcarbamylase deficiency), full gene sequence PAFAH1B1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kDa]) (eg, lissencephaly, Miller-Dieker syndrome), duplication/deletion analysis PARK2 (Parkinson protein 2, E3 ubiquitin protein ligase [parkin]) (eg, Parkinson disease), duplication/deletion analysis PCCA (propionyl CoA carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), duplication/deletion analysis PCDH19 (protocadherin 19) (eg, epileptic encephalopathy), full gene sequence PDHA1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), duplication/deletion analysis PDHB (pyruvate dehydrogenase [lipoamide] beta) (eg, lactic acidosis), full gene sequence PINK1 (PTEN induced putative kinase 1) (eg, Parkinson disease), full gene sequence PKLR (pyruvate kinase, liver and RBC) (eg, pyruvate kinase deficiency), full gene sequence PLP1 (proteolipid protein 1) (eg, Pelizaeus-Merzbacher disease, spastic paraplegia), full gene sequence POU1F1 (POU class 1 homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	PRX (periaxin) (eg, Charcot-Marie-Tooth disease), full gene sequence PQBP1 (polyglutamine binding protein 1) (eg, Renpenning syndrome), full gene sequence PSEN1 (presenilin 1) (eg, Alzheimer disease), full gene sequence RAB7A (RAB7A, member RAS oncogene family) (eg, Charcot-Marie-Tooth disease), full gene sequence RAI1 (retinoic acid induced 1) (eg, Smith-Magenis syndrome), full gene sequence REEP1 (receptor accessory protein 1) (eg, spastic paraplegia), full gene sequence RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2A and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) RPS19 (ribosomal protein S19) (eg, Diamond-Blackfan anemia), full gene sequence RRM2B (ribonucleotide reductase M2 B [TP53 inducible]) (eg, mitochondrial DNA depletion), full gene sequence SCO1 (SCO cytochrome oxidase deficient homolog 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence SDHB (succinate dehydrogenase complex, subunit B, iron sulfur) (eg, hereditary paraganglioma), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), full gene sequence SGCA (sarcoglycan, alpha [50kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCB (sarcoglycan, beta [43kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCD (sarcoglycan, delta [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCE (sarcoglycan, epsilon) (eg, myoclonic dystonia), duplication/deletion analysis SGCG (sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SHOC2 (soc-2 suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), full gene							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence SHOX (short stature homeobox) (eg, Langer mesomelic dysplasia), full gene sequence SIL1 (SIL1 homolog, endoplasmic reticulum chaperone [S. cerevisiae]) (eg, ataxia), full gene sequence SLC2A1 (solute carrier family 2 [facilitated glucose transporter], member 1) (eg, glucose transporter type 1 [GLUT 1] deficiency syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, Allan-Herndon-Dudley syndrome), full gene sequence SLC22A5 (solute carrier family 22 [organic cation/carnitine transporter], member 5) (eg, systemic primary carnitine deficiency), full gene sequence SLC25A20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), full gene sequence SMAD4 (SMAD family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), duplication/deletion analysis SPAST (spastin) (eg, spastic paraplegia), duplication/deletion analysis SPG7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), duplication/deletion analysis SPRED1 (sprouty-related, EVH1 domain containing 1) (eg, Legius syndrome), full gene sequence STAT3 (signal transducer and activator of transcription 3 [acute-phase response factor]) (eg, autosomal dominant hyper-IgE syndrome), targeted sequence analysis (eg, exons 12, 13, 14, 16, 17, 20, 21) STK11 (serine/threonine kinase 11) (eg, Peutz-Jeghers syndrome), full gene sequence SURF1 (surfeit 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence TARDBP (TAR DNA binding protein) (eg, amyotrophic lateral sclerosis), full gene sequence TBX5 (T-box 5) (eg, Holt-Oram syndrome), full gene sequence TCF4 (transcription factor 4) (eg, Pitt-Hopkins syndrome), duplication/deletion analysis TGFBR1 (transforming growth factor, beta receptor 1) (eg, Marfan syndrome), full gene sequence TGFBR2							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(transforming growth factor, beta receptor 2) (eg, Marfan syndrome), full gene sequence THRB (thyroid hormone receptor, beta) (eg, thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of >5 exons TK2 (thymidine kinase 2, mitochondrial) (eg, mitochondrial DNA depletion syndrome), full gene sequence TNNC1 (troponin C type 1 [slow]) (eg, hypertrophic cardiomyopathy or dilated cardiomyopathy), full gene sequence TNNI3 (troponin I, type 3 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TPM1 (tropomyosin 1 [alpha]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), duplication/deletion analysis TYMP (thymidine phosphorylase) (eg, mitochondrial DNA depletion syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), targeted sequence analysis (eg, exons 18-20, 23-25) WT1 (Wilms tumor 1) (eg, Denys-Drash syndrome, familial Wilms tumor), full gene sequence ZEB2 (zinc finger E-box binding homeobox 2) (eg, Mowat-Wilson syndrome), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons) ACADVL (acyl-CoA dehydrogenase, very long chain) (eg, very long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence ACTN4 (actinin, alpha 4) (eg, focal segmental glomerulosclerosis), full gene sequence AFG3L2 (AFG3 ATPase family gene 3-like 2 [S. cerevisiae]) (eg, spinocerebellar ataxia), full gene sequence AIRE (autoimmune regulator) (eg, autoimmune polyendocrinopathy syndrome type 1), full gene sequence ALDH7A1 (aldehyde dehydrogenase 7 family, member A1) (eg, pyridoxine-dependent epilepsy), full gene sequence ANO5 (anoctamin 5) (eg, limb-girdle muscular dystrophy), full gene sequence ANOS1 (anosmin-1) (eg, Kallmann syndrome 1), full gene sequence APP (amyloid beta [A4] precursor protein) (eg, Alzheimer disease), full gene sequence ASS1 (argininosuccinate synthase 1) (eg, citrullinemia type I), full gene sequence ATL1 (atlastin GTPase 1) (eg, spastic paraplegia), full gene sequence ATP1A2 (ATPase, Na+/K+ transporting, alpha 2 polypeptide) (eg, familial hemiplegic migraine), full gene sequence ATP7B (ATPase, Cu++ transporting, beta polypeptide) (eg, Wilson disease), full gene sequence BBS1 (Bardet-Biedl syndrome 1) (eg, Bardet-Biedl syndrome), full gene sequence BBS2 (Bardet-Biedl syndrome 2) (eg, Bardet-Biedl syndrome), full gene sequence BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease, type 1B), full gene sequence BEST1 (bestrophin 1) (eg, vitelliform macular dystrophy), full gene sequence BMPR2 (bone morphogenetic protein receptor, type II [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), full gene sequence BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, Noonan syndrome),	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	full gene sequence BSCL2 (Berardinelli-Seip congenital lipodystrophy 2 [seipin]) (eg, Berardinelli-Seip congenital lipodystrophy), full gene sequence BTK (Bruton agammaglobulinemia tyrosine kinase) (eg, X-linked agammaglobulinemia), full gene sequence CACNB2 (calcium channel, voltage-dependent, beta 2 subunit) (eg, Brugada syndrome), full gene sequence CAPN3 (calpain 3) (eg, limb-girdle muscular dystrophy [LGMD] type 2A, calpainopathy), full gene sequence CBS (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), full gene sequence CDH1 (cadherin 1, type 1, E-cadherin [epithelial]) (eg, hereditary diffuse gastric cancer), full gene sequence CDKL5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), full gene sequence CLCN1 (chloride channel 1, skeletal muscle) (eg, myotonia congenita), full gene sequence CLCNKB (chloride channel, voltage-sensitive Kb) (eg, Bartter syndrome 3 and 4b), full gene sequence CNTNAP2 (contactin-associated protein-like 2) (eg, Pitt-Hopkins-like syndrome 1), full gene sequence COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), duplication/deletion analysis CPT1A (carnitine palmitoyltransferase 1A [liver]) (eg, carnitine palmitoyltransferase 1A [CPT1A] deficiency), full gene sequence CRB1 (crumbs homolog 1 [Drosophila]) (eg, Leber congenital amaurosis), full gene sequence CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), duplication/deletion analysis DBT (dihydrolipoamide branched chain transacylase E2) (eg, maple syrup urine disease, type 2), full gene sequence DLAT (dihydrolipoamide S-acetyltransferase) (eg, pyruvate dehydrogenase E2 deficiency), full gene sequence DLD (dihydrolipoamide dehydrogenase) (eg, maple syrup urine disease, type III), full gene sequence DSC2 (desmocollin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	gene sequence DSG2 (desmoglein 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 10), full gene sequence DSP (desmoplakin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 8), full gene sequence EFHC1 (EF-hand domain [C-terminal] containing 1) (eg, juvenile myoclonic epilepsy), full gene sequence EIF2B3 (eukaryotic translation initiation factor 2B, subunit 3 gamma, 58kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EIF2B4 (eukaryotic translation initiation factor 2B, subunit 4 delta, 67kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EIF2B5 (eukaryotic translation initiation factor 2B, subunit 5 epsilon, 82kDa) (eg, childhood ataxia with central nervous system hypomyelination/vanishing white matter), full gene sequence ENG (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), full gene sequence EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), duplication/deletion analysis FAH (fumarylacetoacetate hydrolase [fumarylacetoacetase]) (eg, tyrosinemia, type 1), full gene sequence FASTKD2 (FAST kinase domains 2) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence FIG4 (FIG4 homolog, SAC1 lipid phosphatase domain containing [S. cerevisiae]) (eg, Charcot-Marie-Tooth disease), full gene sequence FTSJ1 (FtsJ RNA methyltransferase homolog 1 [E. coli]) (eg, X-linked mental retardation 9), full gene sequence FUS (fused in sarcoma) (eg, amyotrophic lateral sclerosis), full gene sequence GAA (glucosidase, alpha; acid) (eg, glycogen storage disease type II [Pompe disease]), full gene sequence GALC (galactosylceramidase) (eg, Krabbe disease), full gene sequence GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), full gene sequence GARS (glycyl-tRNA synthetase) (eg, Charcot-Marie-Tooth disease), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	GCDH (glutaryl-CoA dehydrogenase) (eg, glutaricacidemia type 1), full gene sequence GCK (glucokinase [hexokinase 4]) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence GLUD1 (glutamate dehydrogenase 1) (eg, familial hyperinsulinism), full gene sequence GNE (glucosamine [UDP-N-acetyl]-2-epimerase/N-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [IBM2], Nonaka myopathy), full gene sequence GRN (granulin) (eg, frontotemporal dementia), full gene sequence HADHA (hydroxyacyl-CoA dehydrogenase/3-ketoacyl-CoA thiolase/enoyl-CoA hydratase [trifunctional protein] alpha subunit) (eg, long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence HADHB (hydroxyacyl-CoA dehydrogenase/3-ketoacyl-CoA thiolase/enoyl-CoA hydratase [trifunctional protein], beta subunit) (eg, trifunctional protein deficiency), full gene sequence HEXA (hexosaminidase A, alpha polypeptide) (eg, Tay-Sachs disease), full gene sequence HLCS (HLCS holocarboxylase synthetase) (eg, holocarboxylase synthetase deficiency), full gene sequence HMBS (hydroxymethylbilane synthase) (eg, acute intermittent porphyria), full gene sequence HNF4A (hepatocyte nuclear factor 4, alpha) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence IDUA (iduronidase, alpha-L-) (eg, mucopolysaccharidosis type I), full gene sequence INF2 (inverted formin, FH2 and WH2 domain containing) (eg, focal segmental glomerulosclerosis), full gene sequence IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), duplication/deletion analysis JUP (junction plakoglobin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full gene sequence KCNH2 (potassium voltage-gated channel, subfamily H [eag-related], member 2) (eg, short QT syndrome, long QT syndrome), full gene sequence KCNQ1 (potassium voltage-gated							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	channel, KQT-like subfamily, member 1) (eg, short QT syndrome, long QT syndrome), full gene sequence KCNQ2 (potassium voltage-gated channel, KQT-like subfamily, member 2) (eg, epileptic encephalopathy), full gene sequence LDB3 (LIM domain binding 3) (eg, familial dilated cardiomyopathy, myofibrillar myopathy), full gene sequence LDLR (low density lipoprotein receptor) (eg, familial hypercholesterolemia), full gene sequence LEPR (leptin receptor) (eg, obesity with hypogonadism), full gene sequence LHCGR (luteinizing hormone/choriogonadotropin receptor) (eg, precocious male puberty), full gene sequence LMNA (lamin A/C) (eg, Emery-Dreifuss muscular dystrophy [EDMD1, 2 and 3] limb-girdle muscular dystrophy [LGMD] type 1B, dilated cardiomyopathy [CMD1A], familial partial lipodystrophy [FPLD2]), full gene sequence LRP5 (low density lipoprotein receptor-related protein 5) (eg, osteopetrosis), full gene sequence MAP2K1 (mitogen-activated protein kinase 1) (eg, cardiofaciocutaneous syndrome), full gene sequence MAP2K2 (mitogen-activated protein kinase 2) (eg, cardiofaciocutaneous syndrome), full gene sequence MAPT (microtubule-associated protein tau) (eg, frontotemporal dementia), full gene sequence MCCC1 (methylcrotonoyl-CoA carboxylase 1 [alpha]) (eg, 3-methylcrotonyl-CoA carboxylase deficiency), full gene sequence MCCC2 (methylcrotonoyl-CoA carboxylase 2 [beta]) (eg, 3-methylcrotonyl carboxylase deficiency), full gene sequence MFN2 (mitofusin 2) (eg, Charcot-Marie-Tooth disease), full gene sequence MTM1 (myotubularin 1) (eg, X-linked centronuclear myopathy), full gene sequence MUT (methylmalonyl CoA mutase) (eg, methylmalonic acidemia), full gene sequence MUTYH (mutY homolog [E. coli]) (eg, MYH-associated polyposis), full gene sequence NDUFS1 (NADH dehydrogenase [ubiquinone] Fe-S protein 1, 75kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NF2							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), full gene sequence NOTCH3 (notch 3) (eg, cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy [CADASIL]), targeted sequence analysis (eg, exons 1-23) NPC1 (Niemann-Pick disease, type C1) (eg, Niemann-Pick disease), full gene sequence NPHP1 (nephronophthisis 1 [juvenile]) (eg, Joubert syndrome), full gene sequence NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), duplication/deletion analysis OPTN (optineurin) (eg, amyotrophic lateral sclerosis), full gene sequence PAFAH1B1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kDa]) (eg, lissencephaly, Miller-Dieker syndrome), full gene sequence PAH (phenylalanine hydroxylase) (eg, phenylketonuria), full gene sequence PARK2 (Parkinson protein 2, E3 ubiquitin protein ligase [parkin]) (eg, Parkinson disease), full gene sequence PAX2 (paired box 2) (eg, renal coloboma syndrome), full gene sequence PC (pyruvate carboxylase) (eg, pyruvate carboxylase deficiency), full gene sequence PCCA (propionyl CoA carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), full gene sequence PCCB (propionyl CoA carboxylase, beta polypeptide) (eg, propionic acidemia), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome type 1F), duplication/deletion analysis PCSK9 (proprotein convertase subtilisin/kexin type 9) (eg, familial hypercholesterolemia), full gene sequence PDHA1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), full gene sequence PDHX (pyruvate dehydrogenase complex, component X) (eg, lactic acidosis), full gene sequence PHEX (phosphate-regulating endopeptidase homolog, X-linked) (eg, hypophosphatemic rickets), full gene sequence PKD2 (polycystic kidney disease 2 [autosomal dominant]) (eg, polycystic kidney disease), full							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	gene sequence PKP2 (plakophilin 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 9), full gene sequence PNKD (paroxysmal nonkinesigenic dyskinesia) (eg, paroxysmal nonkinesigenic dyskinesia), full gene sequence POLG (polymerase [DNA directed], gamma) (eg, Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia), full gene sequence POMGNT1 (protein O-linked mannose beta1,2-N acetylglucosaminyltransferase) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence POMT1 (protein-O-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [LGMD] type 2K, Walker-Warburg syndrome), full gene sequence POMT2 (protein-O-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [LGMD] type 2N, Walker-Warburg syndrome), full gene sequence PPOX (protoporphyrinogen oxidase) (eg, variegate porphyria), full gene sequence PRKAG2 (protein kinase, AMP-activated, gamma 2 non-catalytic subunit) (eg, familial hypertrophic cardiomyopathy with Wolff-Parkinson-White syndrome, lethal congenital glycogen storage disease of heart), full gene sequence PRKCG (protein kinase C, gamma) (eg, spinocerebellar ataxia), full gene sequence PSEN2 (presenilin 2 [Alzheimer disease 4]) (eg, Alzheimer disease), full gene sequence PTPN11 (protein tyrosine phosphatase, non-receptor type 11) (eg, Noonan syndrome, LEOPARD syndrome), full gene sequence PYGM (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type V, McArdle disease), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), full gene sequence RET (ret proto-oncogene) (eg, Hirschsprung disease), full gene sequence RPE65 (retinal pigment epithelium-specific protein 65kDa) (eg, retinitis pigmentosa, Leber congenital amaurosis), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	analysis of exons with functionally-confirmed mutations SCN4A (sodium channel, voltage-gated, type IV, alpha subunit) (eg, hyperkalemic periodic paralysis), full gene sequence SCNN1A (sodium channel, nonvoltage-gated 1 alpha) (eg, pseudohypoaldosteronism), full gene sequence SCNN1B (sodium channel, nonvoltage-gated 1, beta) (eg, Liddle syndrome, pseudohypoaldosteronism), full gene sequence SCNN1G (sodium channel, nonvoltage-gated 1, gamma) (eg, Liddle syndrome, pseudohypoaldosteronism), full gene sequence SDHA (succinate dehydrogenase complex, subunit A, flavoprotein [Fp]) (eg, Leigh syndrome, mitochondrial complex II deficiency), full gene sequence SETX (senataxin) (eg, ataxia), full gene sequence SGCE (sarcoglycan, epsilon) (eg, myoclonic dystonia), full gene sequence SH3TC2 (SH3 domain and tetratricopeptide repeats 2) (eg, Charcot-Marie-Tooth disease), full gene sequence SLC9A6 (solute carrier family 9 [sodium/hydrogen exchanger], member 6) (eg, Christianson syndrome), full gene sequence SLC26A4 (solute carrier family 26, member 4) (eg, Pendred syndrome), full gene sequence SLC37A4 (solute carrier family 37 [glucose-6-phosphate transporter], member 4) (eg, glycogen storage disease type Ib), full gene sequence SMAD4 (SMAD family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), full gene sequence SOS1 (son of sevenless homolog 1) (eg, Noonan syndrome, gingival fibromatosis), full gene sequence SPAST (spastin) (eg, spastic paraplegia), full gene sequence SPG7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), full gene sequence STXBP1 (syntaxin-binding protein 1) (eg, epileptic encephalopathy), full gene sequence TAZ (tafazzin) (eg, methylglutaconic aciduria type 2, Barth syndrome), full gene sequence TCF4 (transcription factor 4) (eg, Pitt-Hopkins syndrome), full gene sequence TH (tyrosine hydroxylase) (eg, Segawa syndrome), full gene							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence TMEM43 (transmembrane protein 43) (eg, arrhythmogenic right ventricular cardiomyopathy), full gene sequence TNNT2 (troponin T, type 2 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TRPC6 (transient receptor potential cation channel, subfamily C, member 6) (eg, focal segmental glomerulosclerosis), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), duplication/deletion analysis UBE3A (ubiquitin protein ligase E3A) (eg, Angelman syndrome), full gene sequence UMOD (uromodulin) (eg, glomerulocystic kidney disease with hyperuricemia and isosthenuria), full gene sequence VWF (von Willebrand factor) (von Willebrand disease type 2A), extended targeted sequence analysis (eg, exons 11-16, 24-26, 51, 52) WAS (Wiskott-Aldrich syndrome [eczema-thrombocytopenia]) (eg, Wiskott-Aldrich syndrome), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), full gene sequence AGL (amylo-alpha-1, 6-glucosidase, 4-alpha-glucanotransferase) (eg, glycogen storage disease type III), full gene sequence AHI1 (Abelson helper integration site 1) (eg, Joubert syndrome), full gene sequence APOB (apolipoprotein B) (eg, familial hypercholesterolemia type B) full gene sequence ASPM (asp [abnormal spindle] homolog, microcephaly associated [Drosophila]) (eg, primary microcephaly), full gene sequence CHD7 (chromodomain helicase DNA binding protein 7) (eg, CHARGE syndrome), full gene sequence COL4A4 (collagen, type IV, alpha 4) (eg, Alport syndrome), full gene sequence COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), duplication/deletion analysis COL6A1 (collagen, type VI, alpha 1) (eg, collagen type VI-related disorders), full gene sequence COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), full gene sequence COL6A3 (collagen, type VI, alpha 3) (eg, collagen type VI-related disorders), full gene sequence CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), full gene sequence KDM5C (lysine [K]-specific demethylase 5C) (eg, X-linked mental retardation), full gene sequence KIAA0196 (KIAA0196) (eg, spastic paraplegia), full gene sequence L1CAM (L1 cell adhesion molecule) (eg, MASA syndrome, X-linked hydrocephaly), full gene sequence LAMB2 (laminin, beta 2 [laminin S]) (eg, Pierson syndrome), full gene sequence	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	MYBPC3 (myosin binding protein C, cardiac) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYH6 (myosin, heavy chain 6, cardiac muscle, alpha) (eg, familial dilated cardiomyopathy), full gene sequence MYH7 (myosin, heavy chain 7, cardiac muscle, beta) (eg, familial hypertrophic cardiomyopathy, Liang distal myopathy), full gene sequence MYO7A (myosin VIIA) (eg, Usher syndrome, type 1), full gene sequence NOTCH1 (notch 1) (eg, aortic valve disease), full gene sequence NPHS1 (nephrosis 1, congenital, Finnish type [nephrin]) (eg, congenital Finnish nephrosis), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome, type 1), full gene sequence PKD1 (polycystic kidney disease 1 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence PLCE1 (phospholipase C, epsilon 1) (eg, nephrotic syndrome type 3), full gene sequence SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence SCN5A (sodium channel, voltage-gated, type V, alpha subunit) (eg, familial dilated cardiomyopathy), full gene sequence SLC12A1 (solute carrier family 12 [sodium/potassium/chloride transporters], member 1) (eg, Bartter syndrome), full gene sequence SLC12A3 (solute carrier family 12 [sodium/chloride transporters], member 3) (eg, Gitelman syndrome), full gene sequence SPG11 (spastic paraplegia 11 [autosomal recessive]) (eg, spastic paraplegia), full gene sequence SPTBN2 (spectrin, beta, non-erythrocytic 2) (eg, spinocerebellar ataxia), full gene sequence TMEM67 (transmembrane protein 67) (eg, Joubert syndrome), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), full gene sequence USH1C (Usher syndrome 1C [autosomal recessive, severe]) (eg, Usher syndrome, type 1), full gene sequence VPS13B (vacuolar protein sorting 13 homolog B [yeast])							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(eg, Cohen syndrome), duplication/deletion analysis WDR62 (WD repeat domain 62) (eg, primary autosomal recessive microcephaly), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) ABCA4 (ATP-binding cassette, sub-family A [ABC1], member 4) (eg, Stargardt disease, age-related macular degeneration), full gene sequence ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia), full gene sequence CDH23 (cadherin-related 23) (eg, Usher syndrome, type 1), full gene sequence CEP290 (centrosomal protein 290kDa) (eg, Joubert syndrome), full gene sequence COL1A1 (collagen, type I, alpha 1) (eg, osteogenesis imperfecta, type I), full gene sequence COL1A2 (collagen, type I, alpha 2) (eg, osteogenesis imperfecta, type I), full gene sequence COL4A1 (collagen, type IV, alpha 1) (eg, brain small-vessel disease with hemorrhage), full gene sequence COL4A3 (collagen, type IV, alpha 3 [Goodpasture antigen]) (eg, Alport syndrome), full gene sequence COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), full gene sequence DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy), full gene sequence DYSF (dysferlin, limb girdle muscular dystrophy 2B [autosomal recessive]) (eg, limb-girdle muscular dystrophy), full gene sequence FBN1 (fibrillin 1) (eg, Marfan syndrome), full gene sequence ITPR1 (inositol 1,4,5-trisphosphate receptor, type 1) (eg, spinocerebellar ataxia), full gene sequence LAMA2 (laminin, alpha 2) (eg, congenital muscular dystrophy), full gene sequence LRRK2 (leucine-rich repeat kinase 2) (eg, Parkinson disease), full gene sequence MYH11 (myosin, heavy chain 11, smooth muscle) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence NEB (nebulin) (eg, nemaline myopathy 2), full gene sequence NF1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence PKHD1 (polycystic kidney and hepatic disease 1) (eg, autosomal recessive polycystic kidney disease), full gene sequence RYR1 (ryanodine receptor 1, skeletal)	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	(eg, malignant hyperthermia), full gene sequence RYR2 (ryanodine receptor 2 [cardiac]) (eg, catecholaminergic polymorphic ventricular tachycardia, arrhythmogenic right ventricular dysplasia), full gene sequence or targeted sequence analysis of > 50 exons USH2A (Usher syndrome 2A [autosomal recessive, mild]) (eg, Usher syndrome, type 2), full gene sequence VPS13B (vacuolar protein sorting 13 homolog B [yeast]) (eg, Cohen syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease types 1 and 3), full gene sequence							
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, part of CLFS.	☑
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	Feb 2010	Archival Retrieval for Mutational Analysis	17	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	Jan 2013	Optical Endomicroscopy	15	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb 2007	Manual Microdisection	12	CPT 2008	September 2011	Survey for January 2014 (added 88380 as part of the family).	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb 2007	Manual Microdisection	12	CPT 2008	September 2013	Survey for January 2014 (added 88380 as part of the family).	☑
88384	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88385	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88386	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88387	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88388	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
90769	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90770	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90771	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2023	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (October 2023). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2023	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (October 2023). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2023	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (October 2023). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Apr 2012	Wireless Motility Capsule	27	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	Apr 2010	Colon Motility	21	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
9111X		Jan 2021	Colon Capsule Endoscopy	21	CPT 2022	October 2025		☐
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	April 2015	Liver Elastography	19	CPT 2016	January 2020	Surveyed for January 2020. Decreased.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Apr 2010	Anterior Segment Imaging	22	CPT 2011	April 2015	Survey for October 2015. The RUC noted that it is the specialty societies decision whether 92133 and 92134 need to be surveyed with this service.	☑
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	Apr 2014	Corneal Hysteresis Determination	23	CPT 2015	October 2018	Survey for January 2019.	☑
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	October 2024		☐
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	October 2024		☐
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	Apr 2010	Diabetic Retinopathy Imaging	24	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	October 2024		☐
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	October 2024		☐
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; ocular (oVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	October 2024		☐
92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report; cervical (cVEMP) and ocular (oVEMP)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	October 2024		☐
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	Apr 2015	Arterial Pressure Waveform Analysis	20	CPT 2016	October 2021	Review in 2 years (October 2021)	☐
93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	October 2024		☐
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93299	Code Deleted CPT 2020	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
933X0		Oct 2020	3D Imaging of Cardiac Structures	09	CPT 2022	October 2025		☐
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	Jan 2013	Percutaneous Alcohol Ablation of Septum	17	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
93982	Code Deleted	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
93X1X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
93X2X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
93X3X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
93X4X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93X5X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
93X6X		Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	October 2025		☐
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
946X1		Jan 2021	Outpatient Pulmonary Rehabilitation Services	23	CPT 2022	October 2025		☐
946X2		Jan 2021	Outpatient Pulmonary Rehabilitation Services	23	CPT 2022	October 2025		☐
95700	Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95705	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95706	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95707	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95708	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95709	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95710	Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95716	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95717	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95719	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95721	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95722	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95723	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95724	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95725	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95726	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	October 2023		☐
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Apr 2008	Actigraphy Sleep Assessment	25	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days	Jan 2018	Electrocorticography	18	CPT 2019	October 2022		☐
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	Feb 2009	Nerve Conduction Tests	18	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb 2006	Whole Body Integumentary Photography	19	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	☐
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Oct 2013	HCPAC - Ultrasonic Wound Assessment	17	CPT 2015	October 2018	Survey for January 2019.	☑
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	October 2023		☐
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	October 2023		☐
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	October 2023		☐
989X1		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	October 2025		☐
989X2		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	October 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
989X3		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	October 2025		☐
989X4		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	October 2025		☐
989X5		Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	October 2025		☐
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99363	Code Deleted	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99364	Code Deleted	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)	Apr 2019	Office Visits	09	CPT 2021	October 2024		☐
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	October 2023		☐
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	October 2023		☐
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	October 2023		☐
99439		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	October 2025	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	October 2022		☐
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes	Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	October 2022		☐
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2022		☐
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2023		☐
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)	Jan 2019	Chronic Care Remote Physiologic Monitoring	20	CPT 2020	October 2023		☐
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	Jan 2019	Self-Measured Blood Pressure Monitoring	19	CPT 2020	October 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2021		☐
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2013	October 2025	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99488	Code Deleted	Oct 2012	Complex Chronic Care Coordination Services	09	CPT 2013	October 2017	Code Deleted	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2013	October 2025	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2015	October 2025	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99491		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	October 2025	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2022	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the October 2020 Relativity Assessment Workgroup meeting. The Workgroup recommends	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							postponing the new technology/new services review until October 2022, after the CPT Assistant article has time to take effect.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2022	In January 2020, the RUC identifiedPsychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the October 2020 Relativity Assessment Workgroup meeting. The Workgroup recommends	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							postponing the new technology/new services review until October 2022, after the CPT Assistant article has time to take effect.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2022	In January 2020, the RUC identifiedPsychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the October 2020 Relativity Assessment Workgroup meeting. The Workgroup recommends	☐

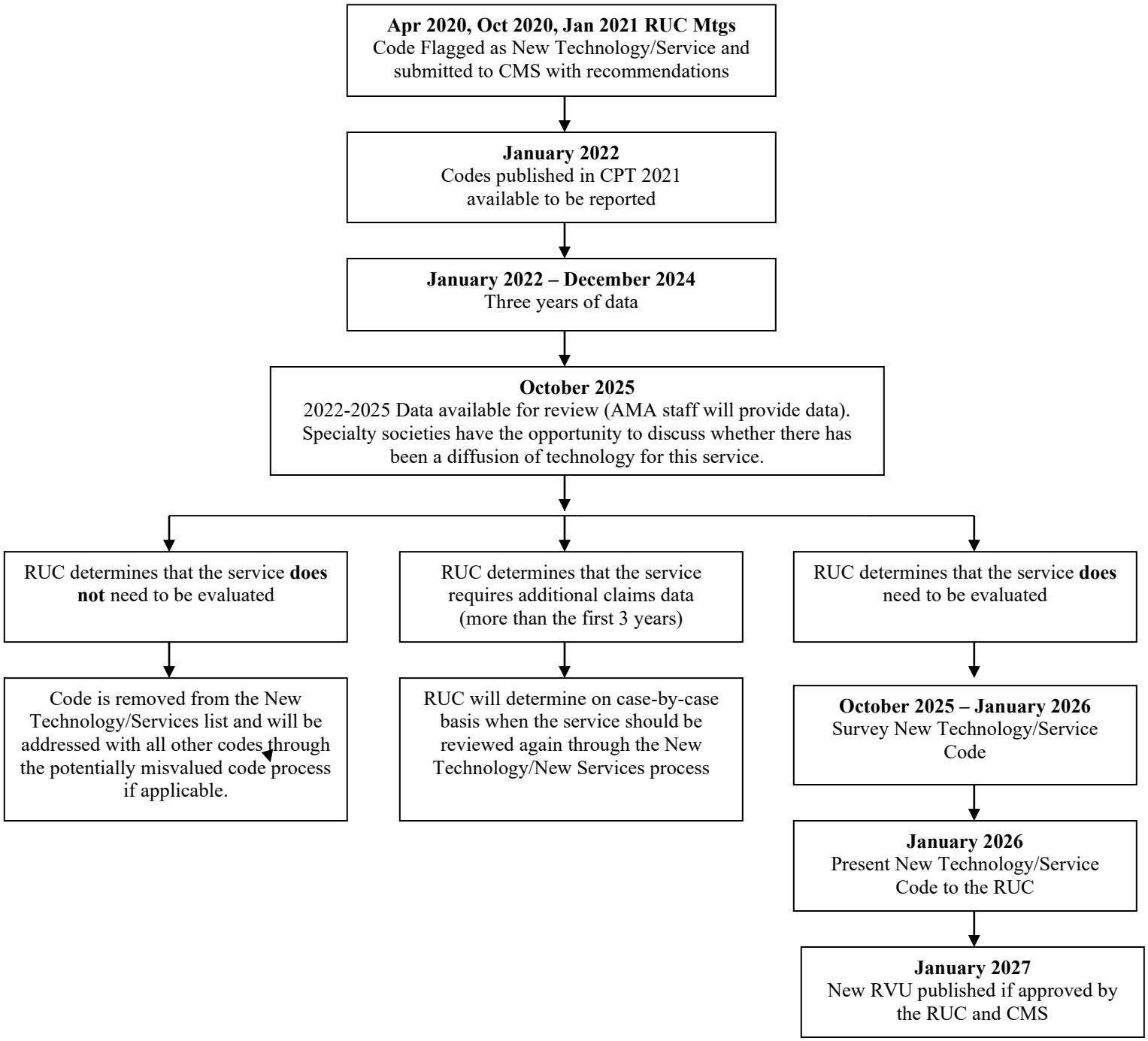
CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							postponing the new technology/new services review until October 2022, after the CPT Assistant article has time to take effect.	
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	☑
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	☑
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	Jan 2014	Advance Care Planning	19	CPT 2015	October 2021	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (October 2021).	☐
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	Jan 2014	Advance Care Planning	19	CPT 2015	October 2021	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (October 2021).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99X21		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	October 2025		☐
99X22		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	October 2025		☐
99X23		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	October 2025		☐
99X24		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	October 2025		☐
99X25		Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	October 2025		☐
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes		Fecal Bacteriotherapy		CPT 2013	October 2018		☑

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example



Revised October 2020

Society	Acronym
Academy of Nutrition and Dietetics	ANDi
AMDA-The Society for Post-Acute and Long-Term Care Medicine	AMDA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Audiology	AAA
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology Association	AADA
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of PAs	AAPA
American Academy of Pediatrics	AAP
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Sleep Medicine	AASM
American Association for Thoracic Surgery	AATS
American Association of Clinical Endocrinologists	AACE
American Association of Clinical Urologist, Inc.	AACU
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic Medicine	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS
American College of Allergy, Asthma & Immunology	ACAAI
American College of Cardiology	ACC
American College of Chest Physicians	CHEST
American College of Emergency Physicians	ACEP
American College of Gastroenterology	ACG
American College of Medical Genetics	ACMG
American College of Mohs Surgery	ACMS

American College of Nuclear Medicine	ACNM
American College of Obstetricians and Gynecologists	ACOG
American College of Physicians	ACP
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACRh
American College of Surgeons	ACS
American Dental Association	ADA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Medical Association	AMA
American Medical Women's Association	AMWA
American Nurses Association	ANA
American Occupational Therapy Association	AOTA
American Optometric Association	AOA
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Physical Therapy Association	APTA
American Podiatric Medical Association	APMA
American Psychiatric Association	APA
American Psychological Association	APA
American Rhinologic Society	ARS
American Roentgen Ray Society	ARRS
American Society for Aesthetic Plastic Surgery	ASAPS
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Radiation Oncology	ASTRO
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Transplantation and Cellular Therapy	ASTCT
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)

American Society of Cytopathology	ASC
American Society of Dermatopathology	ASDP
American Society of Echocardiography	ASE
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Interventional Pain Physicians	ASIPP
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Plastic Surgeons	ASPS
American Society of Retina Specialists	ASRS
American Speech-Language-Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
American Vein and Lymphatic Society	AVLS
Association of University Radiologists	AUR
Centers for Medicare and Medicaid Services	CMS
College of American Pathologists	CAP
Congress of Neurological Surgeons	CNS
Heart Rhythm Society	HRS
Infectious Diseases Society of America	IDSA
International Society for the Advancement of Spine Surgery	ISASS
National Association of Social Workers	NASW
North American Neuromodulation Society	NANS
North American Spine Society	NASS
Obstetrics and Gynecology	ACOG
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Interventional Radiology	SIR
Society of Nuclear Medicine and Molecular Imaging	SNMMI
Society of Thoracic Surgeons	STS
The Endocrine Society	ES
The Society for Cardiovascular Angiography and Interventions	SCAI
The Spine Intervention Society	SIS
Underseas and Hyperbaric Medical Society	UHMS

CPT Code	Long Descriptor	Global	99204	99211	99212	99213	99214	99215	Total CY2021 CMS Proposed NPRM Physician Time - Current	Total CY2020 CMS Proposed NPRM Physician Time with RUC Proposed Office Visit Times	Change in Total Physician Time	Total CY2022 RUC Proposed Surgical Global wRVU - Before Adjustment	RUC Recommended Surgical Global wRVU After Incorporating RUC Proposal for Bundled Visits	Change in Surgical Global wRVU	Change in Clinical Staff Time
22867	Insertion of interlaminar/intersp	090				3			271	292	21	15.00	15.99	0.99	0
64582	Open implantation of hypogloss	090				2			294	308	14	16.00	16.66	0.66	0
64583	Revision or replacement of hypo	090				2			309	323	14	16.50	17.16	0.66	0
64584	Removal of hypoglossal nerve n	090				2			275	289	14	14.00	14.66	0.66	0
64628	Thermal destruction of intraoss	010				1			178	185	7	8.25	8.58	0.33	0
66174	Transluminal dilation of aqueou	090			1	4			173	201	28	8.53	10.07	1.54	0
66175	Transluminal dilation of aqueou	090			1	4			184	212	28	10.25	11.79	1.54	0
66982	Extracapsular cataract removal	090			1	3			175	196	21	10.25	11.46	1.21	0
66984	Extracapsular cataract removal	090			1	2			126	140	14	7.35	8.23	0.88	0
66987	Extracapsular cataract removal	090			1	5			239	274	35	13.15	15.02	1.87	0
66988	Extracapsular cataract removal	090			1	4			202	230	28	10.25	11.79	1.54	0
66989	Extracapsular cataract removal	090			1	3			176	197	21	12.13	13.34	1.21	0
66991	Extracapsular cataract removal	090			1	3			172	193	21	9.23	10.44	1.21	0
69714	Implantation, osseointegrated i	090			1	2			182	196	14	8.69	9.57	0.88	0
69716	Implantation, osseointegrated i	090				2			185	199	14	9.77	10.43	0.66	0
69717	Revision/replacement (including	090			1	2			187	201	14	8.80	9.68	0.88	0
69719	Revision/replacement (including	090				2			186	200	14	9.77	10.43	0.66	0
69726	Removal, osseointegrated impla	090			1	1			148	155	7	5.93	6.48	0.55	0
69727	Removal, osseointegrated impla	090			1	1			164	171	7	7.13	7.68	0.55	0

Office Visit Times	2020 Physician T	2021 CMS time	2020 Worl	2021 Work RVU
99204	45	60	2.43	2.6
99211	7	7	0.18	0.18
99212	16	16	0.48	0.7
99213	23	30	0.97	1.3
99214	40	47	1.5	1.92
99215	55	70	2.11	2.8

2020 Clinical Staff Time	2021 Clinical Staff Time
62	54
19	17
28	28
36	36
53	51
63	62

hAMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

January 2021

Anesthesia Services for Image-Guided Spinal Procedures – Tab 4

In 2017, the RUC identified CPT code 01936 *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic* via the high volume growth screen. The Relativity Assessment Workgroup reviewed data on what procedures are reported with this anesthesia code. The Workgroup noted it was concerned that this service may be reported inappropriately, as the top surgical services reported with 01936 utilization did not show significant increases and some of these services indicate that moderate sedation is included. The Workgroup noted that the specialty society provided significant education on the correct reporting of this service, however, it can not reach all providers of this service or physicians who request the anesthesia service. The Workgroup recommended reviewing 01936 after two years of utilization data were available including the utilization for the top surgical services reported with 01936. In October 2019, the Workgroup reviewed this service and recommended that it be referred to CPT to create more granular codes. In October 2020, the CPT Editorial Panel replaced 01935 and 01936 with six new codes to report percutaneous image-guided spine and spinal cord anesthesia procedures and revised a parenthetical following code 00600 to refer to these newly created CPT codes.

Drainage/Aspiration

01937 ***Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic***
The RUC reviewed the survey results from 41 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 2 minutes intra-operative anesthesia induction period, 15 minutes intra-operative anesthesia post-induction period and 8 minutes post-anesthesia evaluation, totaling 42 minutes.

The majority of survey respondents indicated that the intensity and complexity measures for 01937 are identical to somewhat more intense than top key reference service 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified* (base unit = 5) and identical to somewhat more intense than the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4), which support the base unit recommendation. In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01937 aligns appropriately with the regression line, which supports the recommended base unit.

The specialty societies noted that the surveyed service is performed in the prone position, which adds a significant complexity, necessitating a higher base unit value than the nerve procedure described by reference service list code 01810 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand* (base unit = 3). The surveyed service also has higher intensity and complexity than

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

reference service list code 00812 *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* (base unit = 3). Therefore, a base unit of 4 appropriately values 01937 relative to other anesthesia services. **The RUC recommends a base unit of 4 for CPT code 01937**.

01938 ***Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral***
The RUC reviewed the survey results from 44 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 2 minutes intra-operative anesthesia induction period, 15 minutes intra-operative anesthesia post-induction period and 8 minutes post-anesthesia evaluation, totaling 42 minutes.

The majority of survey respondents that selected each of the corresponding top two key reference services indicated that the intensity and complexity measures for 01938 are identical to somewhat more intense and complex than top key reference service 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified* (base unit = 5) and identical to somewhat more intense than the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4), which support the base unit recommendation. In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01938 aligns appropriately with the regression line, which supports the recommended base unit. The RUC agreed with the survey respondents that these anesthesia for percutaneous image-guided injection drainage or aspiration procedures are the same whether they are performed in the cervical/thoracic (01937) or lumbar/sacral areas (01938).

The specialty societies noted that the surveyed service is performed in the prone position, which adds a significant complexity, necessitating a higher base unit value than the nerve procedure described by reference service list code 01810 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand* (base unit = 3). The surveyed service also has higher intensity and complexity than reference service list code 00812 *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* (base unit = 3). Therefore, a base unit of 4 appropriately values 01938 relative to other anesthesia services. **The RUC recommends a base unit of 4 for CPT code 01938**.

Destruction

01939 ***Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic***
The RUC reviewed the survey results from 40 anesthesiologists and determined that a base unit of 4 appropriately accounts for the work required to perform this service. The RUC noted that the survey 25th percentile and median were both a base unit of 5. However, RUC determined that the anesthesia for percutaneous image-guided destruction by neurolytic agent procedures are the same whether they are performed in the cervical/thoracic (01939) or lumbar/sacral areas (01940), the same as the injection or aspiration services 01937 and 01938.
The RUC recommends 11 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 2 minutes intra-operative anesthesia induction period, 15 minutes intra-operative anesthesia post-induction period and 10 minutes post-anesthesia evaluation,

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

totaling 45 minutes. The RUC recommends for 01939 to have a direct base unit crosswalk to the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4 and 50 minutes total time), thus maintaining the appropriate relativity with 01937, 01938 and 01940, all with a base unit of 4. CPT code 01939 and 00142 are similar anesthesia services both requiring similar precision. The surveyed code requires precision in the tight cervical area with little movement to prevent injury and CPT code 00142 requires precision regarding delicate surgeries to the lens to avoid injury.

The majority of survey respondents indicated that the intensity and complexity measures for 01939 are identical to somewhat more intense than top key reference service 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified* (base unit = 5) and identical to somewhat more intense than the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4), which bracket the base unit recommendation.

The specialty societies noted that the surveyed service is performed in the prone position, which adds a significant complexity, necessitating a higher base unit value than the nerve procedure described by reference service list code 01810 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand* (base unit = 3). The surveyed service also has higher intensity and complexity than reference service list code 00812 *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* (base unit = 3). Therefore, a base unit of 4 appropriately values 01939 relative to other anesthesia services. **The RUC recommends a base unit of 4 for CPT code 01939**.

01940 ***Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral***
The RUC reviewed the survey results from 41 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to perform this service. The RUC recommends 11 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 2 minutes intra-operative anesthesia induction period, 15 minutes intra-operative anesthesia post-induction period and 10 minutes post-anesthesia evaluation, totaling 45 minutes.

The majority of survey respondents that selected each of the corresponding top two key reference services indicated that the intensity and complexity measures for 01940 are identical to somewhat more intense than top key reference service 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified* (base unit = 5) and identical to somewhat more intense than the second top key reference service 00142 *Anesthesia for procedures on eye; lens surgery* (base unit = 4), which support the base unit recommendation. In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01940 aligns appropriately with the regression line, which supports the recommended base unit. The RUC determined that that the anesthesia for percutaneous image-guided destruction by neurolytic agent procedures are the same whether they are performed in the cervical/thoracic (01939) or lumbar/sacral areas (01940), the same as the injection or aspiration services codes 01937 and 01938.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The specialty societies noted that the surveyed service is performed in the prone position, which adds a significant complexity, necessitating a higher base unit value than the nerve procedure described by reference service list code 01810 *Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand* (base unit = 3). The surveyed service also has higher intensity and complexity than reference service list code 00812 *Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy* (base unit = 3). Therefore, a base unit of 4 appropriately values 01940 relative to other anesthesia services. **The RUC recommends a base unit of 4 for CPT code 01940**.

Neuromodulation

01941 ***Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic***

The RUC reviewed the survey results from 47 anesthesiologists and determined that a base unit of 6 appropriately accounts for the work required to perform this service. The RUC recommends 13 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 8 minutes intra-operative anesthesia induction period, 20 minutes intra-operative anesthesia post-induction period and 10 minutes post-anesthesia evaluation, totaling 48 minutes. The RUC noted that the survey median of 7 base units was a bit high and the survey 25th percentile of 5 base units was a bit low compared to other anesthesia services. The RUC noted that the anesthesia reference service list does not contain any services with 6 base units, which reduces the likelihood of a survey respondent estimating 6 base units versus either 5 or 7 base units. Therefore, the RUC recommends that 01941 be crosswalked to 00732 *Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)* (base unit = 6).

In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01941 aligns appropriately with the regression line, which supports the recommended base unit. The RUC determined that that the anesthesia for percutaneous image-guided neuromodulation procedures is the same whether they are performed in the cervical/thoracic (01941) or lumbar/sacral areas (01942), the same as the comparison between the other services in this family.

The specialty society indicated and the RUC agreed that 01941 and 01942 require a more complex anesthetic technique to protect the patients while in the prone position. This position takes extra care prior to the start of the procedure to ensure the airway is properly secured. During the procedure, the patient is unable to protect their own airway, causing the potential for significant complications and requires constant monitoring. Additionally, spinal procedures performed in the prone position cause additional pressure points for the anesthetist to monitor throughout the procedure. These risks and added complexities exist for these procedures performed on the spine.

The complexity of the service, the added comorbidities of the typical patient, and the required constant monitoring of the patient in the prone position support the 6 base unit recommendation for CPT code 01941. **The RUC recommends a base unit of 6 for CPT code 01941**.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

01942 ***Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral***
The RUC reviewed the survey results from 49 anesthesiologists and determined that a base unit of 6 appropriately accounts for the work required to perform this service. The RUC recommends 13 minutes pre-anesthesia patient evaluation time, 7 minutes pre-anesthesia equipment/drug/supply preparation, 8 minutes intra-operative anesthesia induction period, 20 minutes intra-operative anesthesia post-induction period and 10 minutes post-anesthesia evaluation, totaling 48 minutes. The RUC noted that the survey median of 7 base units was a bit high and the survey 25th percentile of 5 base units was a bit low compared to other anesthesia services. The RUC noted that the anesthesia reference service list does not contain any services with 6 base units. Therefore, the RUC recommends that 01942 be crosswalked to 00732 *Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)* (base unit = 6).

In examining anesthesia services, the RUC also uses a regression line to compare all anesthesia services to the 14 reference service list anesthesia codes. Code 01941 aligns appropriately with the regression line, which supports the recommended base unit. The RUC determined that the anesthesia for percutaneous image-guided neuromodulation procedures is the same whether they are performed in the cervical/thoracic (01941) or lumbar/sacral areas (01942), the same as the comparison between the other services in this family.

The specialty society indicated, and the RUC agreed that 01941 and 01942 require a more complex anesthetic technique to protect the patients while in the prone position. This position takes extra care prior to the start of the procedure to ensure the airway is properly secured. During the procedure, the patient is unable to protect their own airway, causing the potential for significant complications and requires constant monitoring. Additionally, spinal procedures performed in the prone position cause additional pressure points for the anesthetist to monitor throughout the procedure. These risks and added complexities exist for procedures performed on the spine.

The complexity of the service, the added comorbidities of the typical patient, and the required constant monitoring of the patient in the prone position support the 6 base unit recommendation for CPT code 01942. **The RUC recommends a base unit of 6 for CPT code 01942**.

Practice Expense
The RUC recommends the anesthesia standard of eight minutes for clinical staff pre-time for the entire family of services.

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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
Anesthesia **Spine and Spinal Cord**				
00600		Anesthesia for procedures on cervical spine or cord; not otherwise specified (For percutaneous image-guided spine or spinal cord anesthesia procedures, see ~~01935, 01936~~ 01937, 01938, 01939, 01940, 01941, 01942)		
		Radiological Procedures		
~~01935~~	-	~~Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic~~	~~XXX~~	N/A
~~01936~~	-	~~therapeutic~~ (01935, 01936 have been deleted) (To report anesthesia for percutaneous image-guided procedures on the spine or spinal cord, see 01937, 01938, 01939, 01940, 01941, 01942)	~~XXX~~	N/A
●01937	H1	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic	XXX	4
●01938	H2	lumbar or sacral (For anesthesia for percutaneous image-guided destruction procedures on the spine or spinal cord, see 01939, 01940)	XXX	4
●01939	H3	Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	XXX	4

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Base Unit Recommendation
●01940	H4	lumbar or sacral (For anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord, see 01937, 01938)	XXX	4
●01941	H5	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	XXX	6
●01942	H6	lumbar or sacral	XXX	6

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:01937 Tracking Number: Original Specialty Recommended Base Unit Value: **4**
Presented Recommended Base Unit Value: 4
Global Period:XXX Current Base Unit Value: **NA** RUC Recommended Base Unit Value: **4**

CPT Descriptor: Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old female has chronic neck pain radiating toward her right shoulder. An MRI demonstrated facet arthropathy at C4-C5 and multilevel degenerative disc disease. Diagnostic testing with cervical facet blocks under fluoroscopic guidance on the right at the C4-C5 level is indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 100.00%

Description of Pre-Service Work: A pre-procedure evaluation and targeted physical examination of the patient is performed. Review laboratory studies, ECG results, and imaging studies as necessary. Discuss with patient anesthetic technique to be used given the nature of the procedure and the requirements of the physician performing the procedure. Obtain informed consent. Set up anesthetic and drugs in preparation for the procedure and check anesthesia equipment, supplies, and monitors. A peripheral intravenous catheter is placed.

Description of Intra-Service Work: In the procedure room, monitoring is established and a presurgical review is performed. The patient is placed in the prone position. Sufficient sedation and analgesia are provided to allow the patient to remain comfortable and cooperative with the procedure. Medications are titrated and the patient is monitored to preserve stable vital signs and adequate respiratory efforts throughout.

At the end of the procedure, the patient is turned supine and transferred to the postanesthetic care unit where a postanesthetic report is provided. Elements of the anesthesia care including vital signs (at least every five minutes), positioning, anesthesia procedures, medications, and significant events are personally documented in the anesthetic record.

Description of Post-Service Work: Appropriate analgesic and/or antiemetic are ordered for postprocedure discomfort, as necessary. Anesthesia equipment and medications are disposed of. A postoperative evaluation is made in the postanesthesia care unit to determine satisfactory recovery from anesthetic care and to determine whether any anesthetic-related complications have occurred. Any postanesthesia care is provided, as needed, in the postanesthesia care unit. The patient is discharged from the unit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Neal Cohen, MD, Gordon Morewood, MD, Richard Rosenquist, MD					
Specialty Society(ies):	American Society of Anesthesiologists					
CPT Code:	01937					
Sample Size:	7404	**Resp n:** 41				
Description of Sample:	Random Sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	

CPT Code: 01937

Service Performance Rate	0.00	0.00	**5.00**	40.00	1000.00
Survey Base Unit Values:	2.00	4.00	**5.00**	6.00	10.00
Pre-Anesthesia Time:					
Pre-Service Evaluation	**4.00**	**8.00**	**10.00**	**15.00**	**30.00**
Equipment/Drug/Supply Preparation	**1.00**	**5.00**	**9.00**	**15.00**	**30.00**
Intra-op Anesthesia Time:					
Induction Period Procedure	1.00	6.00	**8.00**	15.00	25.00
Post-Induction Period Anesthesia	0.00	10.00	**15.00**	20.00	100.00
Post-Anesthesia Evaluation Time:			**8.00**		

SPECIALTY SOCIETY RECOMMENDED DATA

CPT Code: 01937	
	Specialty Recommended
Base Unit Value:	**4.00**
Pre-Anesthesia Time:	
Pre-Service Evaluation	**10.00**
Equipment/Drug/Supply Preparation	**7.00**
Intra-op Anesthesia Time:	
Induction Period Procedure	**2.00**
Pos-Induction Period Anesthesia	**15.00**
Post-Anesthesia Evaluation Time:	**8.00**

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
01630	XXX	5	RUC Time

CPT Descriptor Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00142	XXX	4	**RUC Time**

CPT Descriptor Anesthesia for procedures on eye; lens surgery

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization
CPT Descriptor 1				
MPC CPT Code 2	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization
CPT Descriptor 2				

Other Reference CPT Code	Global	Base Unit Value	Time Source
		0	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 39.0 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 29.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 01937	Top Key CPT Code: 01630	2nd Key CPT Code: 00142
Median Pre-Service Time - Evaluation	10.00	12.00	10.00
Median Pre-Service Time - Equipment/Supply Preparation	7.00	12.00	5.00
Median Intra-Service Time – Induction Period	2.00	15.00	5.00
Median Intra-Service Time – Post-Induction Period	15.00	90.00	25.00
Median Post-service Time	8.00	11.00	5.00
Median Total Time	**42.00**	**140.00**	**50.00**

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	50%	38%	6%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	63%	31%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	56%	38%
Physical effort required	13%	31%	56%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	19%	75%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	42%	58%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	56%	38%
Physical effort required	13%	31%	56%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	42%	50%

Post-Induction Period Procedure Anesthesia Time Allocation

	Survey Code Percentage of Time (%)	**Top Key** Percentage of Time (%)	**2nd Key** Percentage of Time (%)
Level 1 Problems are self-limited or minor; Straightforward medical decision making and treatment	52.95	40.88	67.83
Level 2 Problems are of low severity; Medical decision making and treatment of low complexity	24.68	30.58	18.42
Level 3 Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	10.63	16.90	5.68
Level 4 Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	5.59	7.01	4.14
Level 5 Problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	6.15	4.63	3.92
Total (must total 100%)	101.00%	101.00%	100.00%

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Society of Anesthesiologists (ASA) is pleased to submit an anesthesia base unit recommendation for code 01937 (*Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic).*

Code	Descriptor	Jan RUC 2021 Recommendation	Rationale
01937	**Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic**	**4**	**25th**
01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	4	25th
01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	4	Xwalk
01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	4	25th
01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	6	Xwalk
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	6	Xwalk

Background

CPT code 01937 was created at the October 2020 CPT meeting, along with the entire code family (01937-01942) describing anesthesia for image-guided procedures on the spine. The code family replaces CPT code 01935 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic)* and 01936 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic).*

The new code family was created to provide more granularity for anesthesia services that are used for image-guided procedures on the spine after CPT code 01936 was flagged in 2017 for high volume growth and the RAW recommended that the codes be reviewed by CPT.

The approved methodology to identify the vignette for an anesthesia service is to base the typical patient off of the most common underlying procedure reported with the anesthesia code. Based on an analysis of the Medicare 5% file, the most common procedure billed with the anesthesia procedure (01936) for the same patient on the same day by a different provider, after add-on codes and ancillary codes were removed is:

64490 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

As approved by the RUC Research subcommittee, the vignette used in the survey was from the typical patient described by CPT code 64490.

Expert Panel Recommendation

ASA is recommending the survey 25th percentile of 4 base units for CPT code 01937.

For time we are recommending:

Time Period	Minutes	Source
Pre-Service Evaluation	10	Survey median
Equipment/Drug Supply Preparation	7	Time package: straightforward patient/straightforward anesthetic
Induction Period Procedure	2	Time package: straightforward patient/straightforward anesthetic
Post-Induction Period Anesthesia	15	Survey median
Post-Anesthesia Evaluation	8	Survey median

Survey Sample and Process

The survey data and recommendations are based upon a random sample of 7,404 physician anesthesiologist members of ASA. The surveying society convened an expert panel to review the survey data.

Recommendation Rationale

An expert panel of anesthesiologists was convened to consider the survey data and provide recommendations. In developing recommendations the expert panel considered survey data, key reference codes, the Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis; and Post-Induction Period Procedure Anesthesia (PIPPA).

Survey Data

The panel is recommending the survey 25th percentile of 4 anesthesia base units.

A total of 41 responses were received, 100% of respondents agreed that the patient vignette was typical and the median experience in the past 12 months was 5.

The recommended value is a reduction in base units from the original CPT codes (01935 and 01936), which this new code family is replacing. The expert panel agreed this recommendation was appropriate and that it maintained appropriate rank order in the family.

Key Reference Codes

39% of survey respondents selected 01630 (*Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified*) valued at 5 base units as the top key reference service code.

- 94% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

29% of survey respondents selected 00142 (*Anesthesia for procedures on eye; lens surgery*) valued at 4 base units as the second key reference service code.

- 100% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

The expert panel concluded that the intensity/complexity measures supported their recommendation.

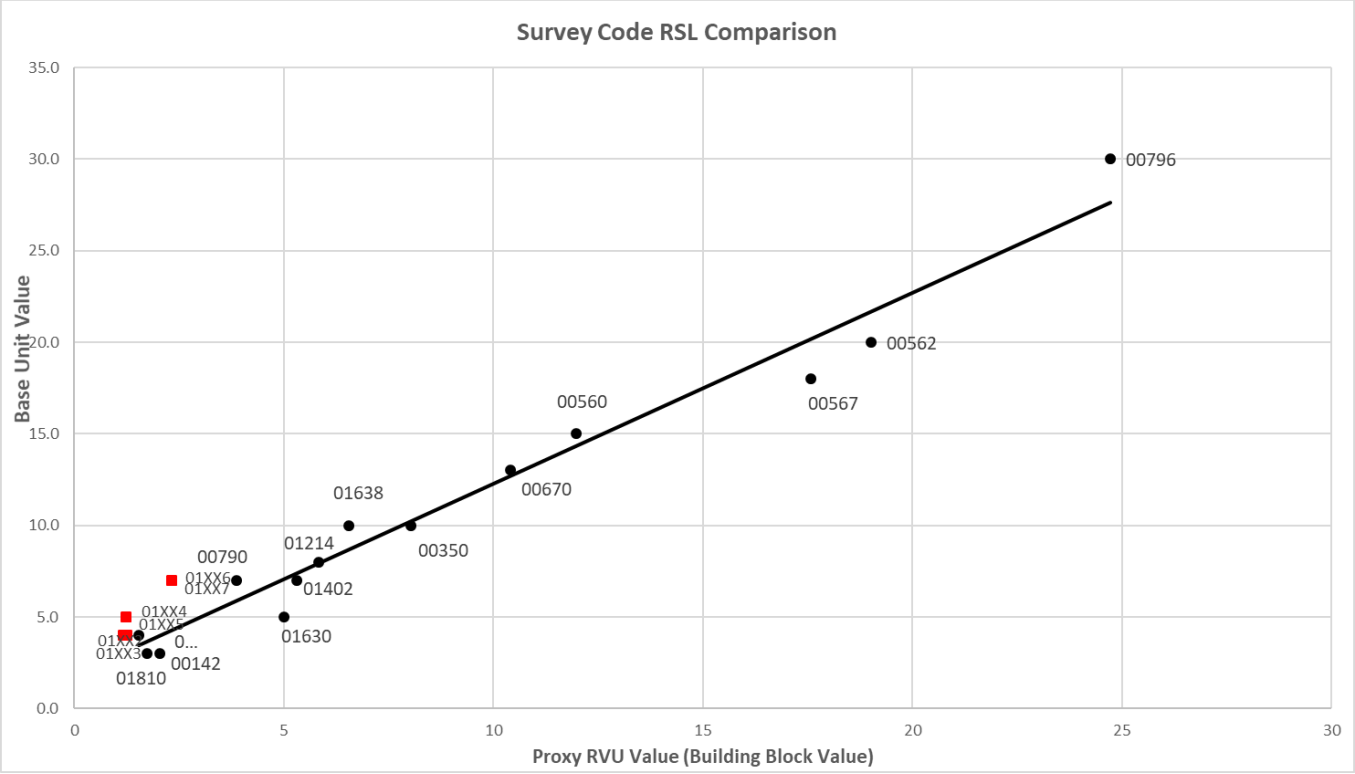
Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis

The RUC recently approved the BBM and RSL Regression Analysis. This supplemental tool to traditional RUC survey techniques is a way to compare relativity among anesthesia services. It is used to validate the presented recommendation. Using survey data and the RUC approved time packages, the expert panel calculated the BBM value known as a "proxy RVU." This value was plotted on the "Survey Code RSL Comparison Graph." This is a linear regression

analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values ("proxy RVUs"). The proxy RVU for 01937 was plotted on the graph. The closer a point is to the regression line, the better the proxy RVU and the base unit align, regardless if the point is above or below the regression line.

The recommended value was supported when the calculated proxy RVU was plotted on the RSL Regression Analysis Graph. The proxy RVU value for 01937 is plotted close to the graph with the base unit recommendation of 4 base units, indicating that the recommendation maintains appropriate rank order when compared to the other codes on the Anesthesia RSL.

The regression line tool developed by the Anesthesia Workgroup is a line of best fit, and by definition will have data points above and below the regression line. Two data points that are equidistant from the regression line, either above or below the line, would be equally supported by the model. In evaluating the plotted data points for the recommended base unit values, the expert panel believes the data points support the recommendations which are based on survey data and clinical expertise.



Anesthesia RSL and Surveyed Code 01937

CPT Code	Long Descriptor	Anesthesia Base Units	BBM Value
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3.0	1.735
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.0	1.857
00142	Anesthesia for procedures on eye; lens surgery	4.0	1.538
01937	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic	4.0	1.19

01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.0	4.772
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7.0	3.858
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.0	5.309
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.0	5.833
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.0	8.841
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.0	6.550
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.0	10.406
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.0	11.965
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.0	17.577
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20.0	19.006
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.0	24.719

Post-Induction Period Procedure Anesthesia (PIPPA)

PIPPA is a relative intensity methodology used by the RUC to validate anesthesia base unit values. It is important to remember that PIPPA only looks at the post-induction period and estimates of varying levels of intensity. PIPPA does not account for differences in intensity of induction of anesthesia (part of intra-service work), or any work done in the pre or post service period. Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels. Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another.

Conceptually, it may be considered the time for the surgeon to perform the procedure. The level of intensity and complexity during the PIPPA period is divided into five levels, or quintiles, each of which has its own descriptor. Survey respondents rate the percentage of the total PIPPA time that the typical patient falls under each of the quintiles. During its third five-year review, which was initiated in February 2005, the RUC assigned intensity values to each quintile. Intensity values do not appear on the RUC survey. The survey responses are used to determine a weighted average of the combined PIPPA intensity/complexity value. PIPPA values do not determine base unit values, but may be used to validate the reasonableness of proposed values.

RUC Assigned PIPPA Intensity Values	
Level 1: Presenting problems are self-limited or minor. Straightforward medical decision-making and treatment.	0.031
Level 2: Problems are of low intensity. Medical decision-making and treatment of low complexity.	0.044
Level 3: Problems are of moderate severity. Medical decision making and treatment of moderate complexity.	0.055
Level 4: Problems are of moderate to high severity. Medical decision-making of moderate to high complexity and treatment of high complexity. Critically ill or critically injured patients.	0.070
Level 5: Problems are of high severity medical decision making and treatment of high complexity. Critically ill or critically injured patients.	0.090

The weighted average PIPPA for 01937 is 0.0429. This value validates the recommendation of 4 base units in comparison with other codes on the Anesthesia RSL. PIPPA is used to validate recommendations and not establish recommended base unit values.

The weighted PIPPA intensity for 01937 is consistent with other codes of similar value on the anesthesia RSL. The expert panel believes the distribution of PIPPA, provides additional confirmation of the appropriateness of the recommended value of 4 base units for 01937.

Code	Descriptor	Base Unit	Weighted PIPPA Intensity	Level 1	Level 2	Level 3	Level 4	Level 5
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3	0.0406	58.02%	24.69%	7.89%	5.38%	4.02%
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3	0.0406	58.35%	24.03%	8.59%	4.66%	4.37%
01937	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic	4	0.0429	52.95%	24.68%	10.63%	5.59%	6.15%
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5	0.0445	40.88%	30.58%	16.90%	7.01%	4.63%

Budget Neutrality

In drafting recommendations for this code family, the specialty society considered the impact of the recommendation on budget neutrality. Based on the presented base unit recommendations and utilization, there is a resulting negative impact on total base units (-0.47%) across the entire family.

The pattern of base units proposed provides the best balance between the survey responses, expert panel opinion regarding rank order within the family, and budget neutrality.

In conclusion, ASA is recommending the survey 25th percentile of 4 anesthesia base units. For time the specialty is recommending:

- Pre-Anesthesia

- *Evaluation:* 10 minutes
- *Equipment/Drug/Supple preparation:* 7 minutes

- Intra-op
  - *Induction:* 2 minutes
  - *Post-induction:* 15 minutes
- *Post-induction:* 8 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 01935 and 01936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Physician Anesthesiologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 60,296
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 60,296 Percentage 100%

Specialty Frequency Percentage

Specialty Frequency Percentage

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,099 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology	Frequency 20,099	Percentage	100.00%

Specialty	Frequency	Percentage

Specialty	Frequency	Percentage

Do many physicians perform this service across the United States? Yes

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:01938 Tracking Number: Original Specialty Recommended Base Unit Value: **4**
Presented Recommended Base Unit Value: 4
Global Period:XXX Current Base Unit Value: **NA** RUC Recommended Base Unit Value: **4**

CPT Descriptor: Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old male presents with recurrent right leg pain, the ability to stand for only 10 minutes and walk less than one block, and minimal problems sitting. The patient's history includes a previous laminectomy at L4-L5; MRI with contrast material, showing a small recurrent herniation between L4-L5 with scar tissue; and neurodiagnostic studies compatible with L5 radiculopathy. He undergoes a transforaminal epidural injection of an anesthetic and/or anti-inflammatory agent at the L5-SI level.

Percentage of Survey Respondents who found Vignette to be Typical: 100.00%

Description of Pre-Service Work: A pre-procedure evaluation and targeted physical examination of the patient is performed. Review laboratory studies, ECG results, and imaging studies as necessary. Discuss with patient anesthetic technique to be used given the nature of the procedure and the requirements of the physician performing the procedure. Obtain informed consent. Set up anesthetic and drugs in preparation for the procedure and check anesthesia equipment, supplies, and monitors. A peripheral intravenous catheter is placed.

Description of Intra-Service Work: In the procedure room, monitoring is established and a presurgical review is performed. The patient is placed in the prone position. Sufficient sedation and analgesia are provided to allow the patient to remain comfortable and cooperative with the procedure. Medications are titrated and the patient is monitored to preserve stable vital signs and adequate respiratory efforts throughout.

At the end of the procedure, the patient is turned supine and transferred to the postanesthetic care unit where a postanesthetic report is provided. Elements of the anesthesia care including vital signs (at least every five minutes), positioning, anesthesia procedures, medications, and significant events are personally documented in the anesthetic record.

Description of Post-Service Work: Appropriate analgesic and/or antiemetic are ordered for postprocedure discomfort, as necessary. Anesthesia equipment and medications are disposed of. A postoperative evaluation is made in the postanesthesia care unit to determine satisfactory recovery from anesthetic care and to determine whether any anesthetic-related complications have occurred. Any postanesthesia care is provided, as needed, in the postanesthesia care unit. The patient is discharged from the unit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021	
Presenter(s):	Neal Cohen, MD, Gordon Morewood, MD, Richard Rosenquist, MD	
Specialty Society(ies):	American Society of Anesthesiologists	
CPT Code:	01938	
Sample Size:	7404	**Resp n:** 44
Description of Sample:	Random Sample	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	42.50	1000.00
Survey Base Unit Values:	2.00	4.00	**5.00**	5.00	10.00
Pre-Anesthesia Time:					
Pre-Service Evaluation	**3.00**	**6.00**	**10.00**	**15.00**	**53.00**
Equipment/Drug/Supply Preparation	**1.00**	**5.00**	**8.00**	**12.75**	**30.00**
Intra-op Anesthesia Time:					
Induction Period Procedure	1.00	6.00	**9.00**	14.25	25.00
Post-Induction Period Anesthesia	0.00	9.50	**15.00**	20.50	90.00
Post-Anesthesia Evaluation Time:			**8.00**		

SPECIALTY SOCIETY RECOMMENDED DATA

CPT Code: 01938	
	Specialty Recommended
Base Unit Value:	**4.00**
Pre-Anesthesia Time:	
Pre-Service Evaluation	**10.00**
Equipment/Drug/Supply Preparation	**7.00**
Intra-op Anesthesia Time:	
Induction Period Procedure	**2.00**
Pos-Induction Period Anesthesia	**15.00**
Post-Anesthesia Evaluation Time:	**8.00**

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
01630	XXX	5	RUC Time

CPT Descriptor Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00142	XXX	4	**RUC Time**

CPT Descriptor Anesthesia for procedures on eye; lens surgery

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization
CPT Descriptor 1				
MPC CPT Code 2	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization
CPT Descriptor 2				

Other Reference CPT Code	Global	Base Unit Value	Time Source
		0	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 34.0 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 01938	Top Key CPT Code: 01630	2nd Key CPT Code: 00142
Median Pre-Service Time - Evaluation	10.00	12.00	10.00
Median Pre-Service Time - Equipment/Supply Preparation	7.00	12.00	5.00
Median Intra-Service Time – Induction Period	2.00	15.00	5.00
Median Intra-Service Time – Post-Induction Period	15.00	90.00	25.00
Median Post-service Time	8.00	11.00	5.00
Median Total Time	**42.00**	**140.00**	**50.00**

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	60%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	80%	13%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	73%	20%
Physical effort required	33%	20%	47%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	40%	53%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	36%	64%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	36%	55%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	55%	45%
Physical effort required	0%	36%	64%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	27%	64%

Post-Induction Period Procedure Anesthesia Time Allocation

	Survey Code Percentage of Time (%)	**Top Key** Percentage of Time (%)	**2nd Key** Percentage of Time (%)
Level 1 Problems are self-limited or minor; Straightforward medical decision making and treatment	55.50	40.88	67.83
Level 2 Problems are of low severity; Medical decision making and treatment of low complexity	25.52	30.58	18.42
Level 3 Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	9.68	16.90	5.68
Level 4 Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	4.45	7.01	4.14
Level 5 Problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	4.84	4.63	3.92
Total (must total 100%)	101.00%	101.00%	100.00%

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Society of Anesthesiologists (ASA) is pleased to submit an anesthesia base unit recommendation for code 01938 (*Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral).*

Code	Descriptor	Jan RUC 2021 Recommendation	Rationale
01937	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic	4	25th
01938	**Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral**	**4**	**25th**
01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	4	Xwalk
01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	4	25th
01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	6	Xwalk
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	6	Xwalk

CPT code 01938 was created in October 2020, along with the entire code family (01937-01942) describing anesthesia for image-guided procedures on the spine. The code family replaces CPT code 01935 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic)* and 01936 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic).*

The new code family was created to provide more granularity for anesthesia services that are used for image-guided procedures on the spine after CPT code 01936 was flagged in 2017 for high volume growth and the RAW recommended that the codes be reviewed by CPT.

The approved methodology to identify the vignette for an anesthesia service is to base the typical patient off of the most common underlying procedure reported with the anesthesia code. Based on an analysis of the Medicare 5% file, the most common procedure billed with the anesthesia procedure (01936) for the same patient on the same day with by a different provider, after add-on codes and ancillary codes were removed is:

64483 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

As approved by the RUC Research subcommittee, the vignette used in the survey was from the typical patient described by CPT code 64483.

Expert Panel Recommendation

ASA is recommending the survey 25th percentile of 4 base units for CPT code 01938.

For time we are recommending:

Time Period	Minutes	Source

Pre-Service Evaluation	10	Survey median
Equipment/Drug Supply Preparation	7	Time package: straightforward patient/straightforward anesthetic
Induction Period Procedure	2	Time package: straightforward patient/straightforward anesthetic
Post-Induction Period Anesthesia	15	Survey median
Post-Anesthesia Evaluation	8	Survey median

Survey Sample and Process

The survey data and recommendations are based upon a random sample of 7,404 physician anesthesiologist members of ASA. The surveying society convened an expert panel to review the survey data.

Recommendation Rationale

An expert panel of anesthesiologists was convened to consider the survey data and provide recommendations. In developing recommendations the expert panel considered survey data, key reference codes, the Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis; and Post-Induction Period Procedure Anesthesia (PIPPA).

Survey Data

The panel is recommending the survey 25th percentile of 4 anesthesia base units.

A total of 44 responses were received, 100% of respondents found the patient vignette to be typical and the median experience in the past 12 months was 5.

The recommended value is a reduction in base units from the original CPT codes (01935 and 01936), which this new code family is replacing. The expert panel agreed this recommendation was appropriate and that it maintained appropriate rank order in the family.

Key Reference Codes

34% of survey respondents selected 01630 (*Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified*) valued at 5 base units as the top key reference service code.

- 93% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

25% of survey respondents selected 00142 (*Anesthesia for procedures on eye; lens surgery*) valued at 4 base units as the second key reference service code.

- 100% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

The expert panel concluded that the intensity/complexity measures supported their recommendation.

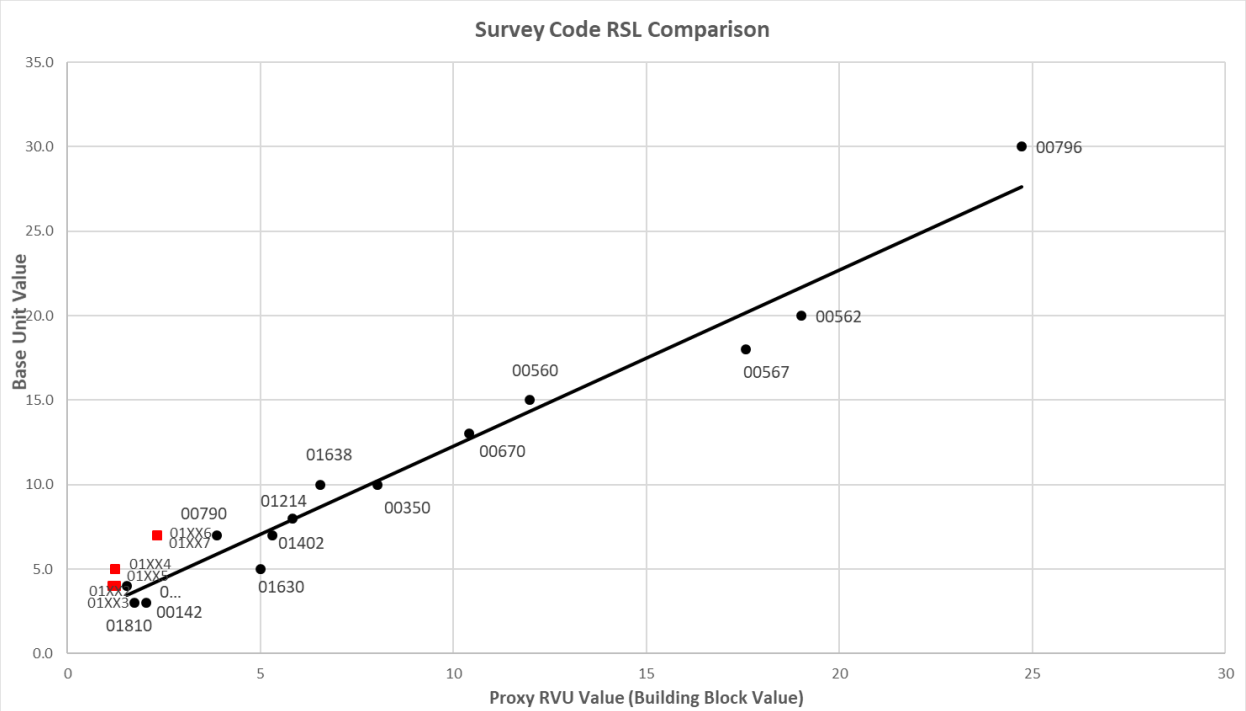
Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis

The RUC recently approved the BBM and RSL Regression Analysis. This supplemental tool to traditional RUC survey techniques is a way to compare relativity among anesthesia services. It is used to validate the presented recommendation. Using survey data and the RUC approved time packages, the expert panel calculated the BBM value known as a "proxy RVU." This value was plotted on the "Survey Code RSL Comparison Graph." This is a linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values

("proxy RVUs"). The proxy RVU for 01938 was plotted on the graph. The closer a point is to the regression line, the better the proxy RVU and the base unit align, regardless if the point is above or below the regression line.

The recommended value is supported when it was plotted on the RSL Regression Analysis Graph. The proxy RVU value for 01938 is plotted close to the graph with the base unit recommendation of 4 base units, indicating that the recommendation maintains appropriate ran order when compared to the other codes on the Anesthesia RSL.

The regression line tool developed by the Anesthesia Workgroup is a line of best fit, and by definition will have data points above and below the regression line. Two data points that are equidistant from the regression line, either above or below the line, would be equally supported by the model. In evaluating the plotted data points for the recommended base unit values, the expert panel believes the data points support the recommendations which are based on survey data and clinical expertise.



Anesthesia RSL and Surveyed Code 01938

CPT Code	Long Descriptor	Anesthesia Base Units	BBM Value
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3.0	1.735
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.0	1.857
00142	Anesthesia for procedures on eye; lens surgery	4.0	1.538
01938	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; lumbar or sacral	4.0	1.17
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.0	4.772
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7.0	3.858

01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.0	5.309
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.0	5.833
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.0	8.841
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.0	6.550
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.0	10.406
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.0	11.965
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.0	17.577
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20.0	19.006
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.0	24.719

Post-Induction Period Procedure Anesthesia (PIPPA)

PIPPA is a relative intensity methodology used by the RUC to validate anesthesia base unit values. It is important to remember that PIPPA only looks at the post-induction period and estimates of varying levels of intensity. PIPPA does not account for differences in intensity of induction of anesthesia (part of intra-service work), or any work done in the pre or post service period. Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels. Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another.

Conceptually, it may be considered the time for the surgeon to perform the procedure. The level of intensity and complexity during the PIPPA period is divided into five levels, or quintiles, each of which has its own descriptor. Survey respondents rate the percentage of the total PIPPA time that the typical patient falls under each of the quintiles. During its third five-year review, which was initiated in February 2005, the RUC assigned intensity values to each quintile. Intensity values do not appear on the RUC survey. The survey responses are used to determine a weighted average of the combined PIPPA intensity/complexity value. PIPPA values do not determine base unit values, but may be used to validate the reasonableness of proposed values.

RUC Assigned PIPPA Intensity Values	
Level 1: Presenting problems are self-limited or minor. Straightforward medical decision-making and treatment.	0.031
Level 2: Problems are of low intensity. Medical decision-making and treatment of low complexity.	0.044
Level 3: Problems are of moderate severity. Medical decision making and treatment of moderate complexity.	0.055

Level 4: Problems are of moderate to high severity. Medical decision-making of moderate to high complexity and treatment of high complexity. Critically ill or critically injured patients.	0.070
Level 5: Problems are of high severity medical decision making and treatment of high complexity. Critically ill or critically injured patients.	0.090

The weighted average PIPPA for 01938 is 0.0415. This value validates the recommendation of 4 base units in comparison with other codes on the Anesthesia RSL. PIPPA is used to validate recommendations and not establish recommended base unit values.

The weighted PIPPA intensity for 01938 is consistent with other codes of similar value on the anesthesia RSL. The expert panel believes the distribution of PIPPA, confirms the recommended value of 4 base units for 01938.

Code	Descriptor	Base Unit	Weighted PIPPA Intensity	Level 1	Level 2	Level 3	Level 4	Level 5
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3	0.0406	58.02%	24.69%	7.89%	5.38%	4.02%
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3	0.0406	58.35%	24.03%	8.59%	4.66%	4.37%
01938	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; lumbar or sacral	4	0.0415	55.50%	25.52%	9.68%	4.45%	4.84%
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5	0.0445	40.88%	30.58%	16.90%	7.01%	4.63%

Budget Neutrality

In drafting recommendations for this code family, the specialty society considered the impact of the recommendation on budget neutrality. Based on the presented base unit recommendations and utilization, there is a resulting negative impact on total base units (-0.47%) across the entire family.

The pattern of base units proposed provides the best balance between the survey responses, expert panel opinion regarding rank order within the family, and budget neutrality.

In conclusion, ASA is recommending the survey 25th percentile of 4 anesthesia base units. For time the specialty is recommending:

- Pre-Anesthesia
  - *Evaluation:* 10 minutes
  - *Equipment/Drug/Supple preparation:* 7 minutes
- Intra-op
  - *Induction:* 2 minutes
  - *Post-induction:* 15 minutes
- *Post-induction:* 8 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 01935 and 01936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Physician Anesthesiologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 237,009
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 237,009 Percentage 100%

Specialty Frequency Percentage

Specialty Frequency Percentage

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 79,003 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 79,003 Percentage 100.00%

Specialty Frequency Percentage

Specialty Frequency Percentage

Do many physicians perform this service across the United States? Yes

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:01939 Tracking Number: Original Specialty Recommended Base Unit Value: **5**
Presented Recommended Base Unit Value: 5
Global Period:XXX Current Base Unit Value: **NA** RUC Recommended Base Unit Value: **4**

CPT Descriptor: Anesthesia for image guided destruction procedures by neurolytic agent on the spine and spinal cord; cervical or thoracic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female with constant neck pain caused by degenerative disc disease and cervical spondylosis received insufficient relief with conservative treatments. Previous trials of cervical medial branch nerve blocks proved beneficial (separately reported). Radiofrequency neurotomy is performed on two medial branch nerves innervating the unilateral symptomatic facet joint.

Percentage of Survey Respondents who found Vignette to be Typical: 100.00%

Description of Pre-Service Work: A pre-procedure evaluation and targeted physical examination of the patient is performed. Review laboratory studies, ECG results, and imaging studies as necessary. Discuss with patient anesthetic technique to be used given the nature of the procedure and the requirements of the physician performing the procedure. Obtain informed consent. Set up anesthetic and drugs in preparation for the procedure and check anesthesia equipment, supplies, and monitors. A peripheral intravenous catheter is placed.

Description of Intra-Service Work: In the procedure room, monitoring is established and a presurgical review is performed. The patient is placed in the prone position with special care to avoid positioning injuries. Sufficient sedation and analgesia are provided to allow the patient to remain comfortable and cooperative with the procedure. Medications are titrated and the patient is monitored to preserve stable vital signs and adequate respiratory efforts throughout.

At the end of the procedure, the patient is turned supine and transferred to the postanesthetic care unit where a postanesthetic report is provided. Elements of the anesthesia care including vital signs (at least every five minutes), positioning, anesthesia procedures, medications, and significant events are personally documented in the anesthetic record.

Description of Post-Service Work: Appropriate analgesic and/or antiemetic are ordered for postprocedure discomfort, as necessary. Anesthesia equipment and medications are disposed of. A postoperative evaluation is made in the postanesthesia care unit to determine satisfactory recovery from anesthetic care and to determine whether any anesthetic-related complications have occurred. Any postanesthesia care is provided, as needed, in the postanesthesia care unit. The patient is discharged from the unit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021	
Presenter(s):	Neal Cohen, MD, Gordon Morewood, MD, Richard Rosenquist, MD	
Specialty Society(ies):	American Society of Anesthesiologists	
CPT Code:	01939	
Sample Size:	7404	**Resp n:** 40
Description of Sample:	Random Sample	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**3.00**	20.00	600.00
Survey Base Unit Values:	3.00	5.00	**5.00**	7.00	20.00
Pre-Anesthesia Time:					
Pre-Service Evaluation	**4.00**	**7.50**	**10.50**	**15.00**	**35.00**
Equipment/Drug/Supply Preparation	**1.00**	**5.75**	**10.00**	**15.00**	**30.00**
Intra-op Anesthesia Time:					
Induction Period Procedure	1.00	6.00	**10.00**	15.00	30.00
Post-Induction Period Anesthesia	0.00	10.00	**15.00**	30.00	110.00
Post-Anesthesia Evaluation Time:			**9.50**		

SPECIALTY SOCIETY RECOMMENDED DATA

CPT Code: 01939	
	Specialty Recommended
Base Unit Value:	**4.00**
Pre-Anesthesia Time:	
Pre-Service Evaluation	**11.00**
Equipment/Drug/Supply Preparation	**7.00**
Intra-op Anesthesia Time:	
Induction Period Procedure	**2.00**
Pos-Induction Period Anesthesia	**15.00**
Post-Anesthesia Evaluation Time:	**10.00**

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
01630	XXX	5	RUC Time

CPT Descriptor Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00142	XXX	4	**RUC Time**

CPT Descriptor Anesthesia for procedures on eye; lens surgery

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization
CPT Descriptor 1				
MPC CPT Code 2	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization
CPT Descriptor 2				

Other Reference CPT Code	Global	Base Unit Value	Time Source
		0	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 45.0 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 22.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 01939	Top Key CPT Code: 01630	2nd Key CPT Code: 00142
Median Pre-Service Time - Evaluation	11.00	12.00	10.00
Median Pre-Service Time - Equipment/Supply Preparation	7.00	12.00	5.00
Median Intra-Service Time – Induction Period	2.00	15.00	5.00
Median Intra-Service Time – Post-Induction Period	15.00	90.00	25.00
Median Post-service Time	10.00	11.00	5.00
Median Total Time	**45.00**	**140.00**	**50.00**

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	33%	56%	5%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	45%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	39%	55%
Physical effort required	22%	17%	61%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	28%	72%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	67%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	44%	56%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	56%	33%
Physical effort required	0%	67%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Post-Induction Period Procedure Anesthesia Time Allocation

	Survey Code Percentage of Time (%)	**Top Key** Percentage of Time (%)	**2nd Key** Percentage of Time (%)
Level 1 Problems are self-limited or minor; Straightforward medical decision making and treatment	47.28	40.88	67.83
Level 2 Problems are of low severity; Medical decision making and treatment of low complexity	28.28	30.58	18.42
Level 3 Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	12.50	16.90	5.68
Level 4 Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	6.65	7.01	4.14
Level 5 Problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	5.30	4.63	3.92
Total (must total 100%)	99.00%	101.00%	100.00%

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Society of Anesthesiologists (ASA) is pleased to submit anesthesia base unit recommendations for code 01939 *(Anesthesia for image guided destruction procedures by neurolytic agent on the spine and spinal cord; cervical or thoracic).*

Code	Descriptor	Jan RUC 2021 Recommendation	Rationale
01937	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic	4	25th
01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	4	25th
01939	**Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic**	**4**	**Xwalk**
01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	4	25th
01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	7	Median
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	7	Median

Background

CPT code 01939 was created in October 2020, along with the entire code family 01937-01942) describing anesthesia for image-guided procedures on the spine. The code family replaces CPT code 01935 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic)* and 01936 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic).*

The new code family was created to provide more granularity for anesthesia services that are used for image-guided procedures on the spine after CPT code 01936 was flagged in 2017 for high volume growth and the RAW recommended that the codes be reviewed by CPT.

The approved methodology to identify the vignette for an anesthesia service is to base the typical patient off of the most common underlying procedure reported with the anesthesia code. Based on an analysis of the Medicare 5% file, the most common procedure billed with the anesthesia procedure (01936) for the same patient on the same day by a different provider, after add-on codes and ancillary codes were removed is:

64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

As approved by the RUC Research subcommittee, the vignette used in the survey was from the typical patient described by CPT code 64633.

Expert Panel Recommendation

ASA is recommending the survey 25th percentile of 5 base units for CPT code 01939.

For time we are recommending:

Time Period	Minutes	Source
Pre-Service Evaluation	11	Survey median
Equipment/Drug Supply Preparation	7	Time package: straightforward patient/straightforward anesthetic
Induction Period Procedure	2	Time package: straightforward patient/straightforward anesthetic
Post-Induction Period Anesthesia	15	Survey median
Post-Anesthesia Evaluation	10	Survey median

Survey Sample and Process

The survey data and recommendations are based upon a random sample of 7,404 physician anesthesiologist members of ASA. The surveying society convened an expert panel to review the survey data.

Recommendation Rationale

An expert panel of anesthesiologists was convened to consider the survey data and provide recommendations. In developing recommendations the expert panel considered survey data, key reference codes, the Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis; and Post-Induction Period Procedure Anesthesia (PIPPA).

Survey Data

A total of 40 responses were received, 100% of respondents agreed the patient vignette was typical and the median experience in the past 12 months was 3.

The recommended value maintains the base unit value from the original CPT codes (01935 and 01936), which this new code family is replacing. The expert panel agreed this recommendation was appropriate and that it maintained appropriate rank order in the family.

Key Reference Codes

45% of survey respondents selected 01630 (*Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified*) valued at 5 base units as the top key reference service code.

- 94% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

23% of survey respondents selected 00142 (*Anesthesia for procedures on eye; lens surgery*) valued at 4 base units as the second key reference service code.

- 100% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

The expert panel concluded that the intensity/complexity measures supported their recommendation.

Comparison with Paired Spinal Code (01940)

CPT code 01939 is reported for services performed in the cervical or thoracic region whereas 01940 is used for services in the lumbar or sacral regions. Procedures performed in the cervical or thoracic region are inherently more complex and have higher associated risk.

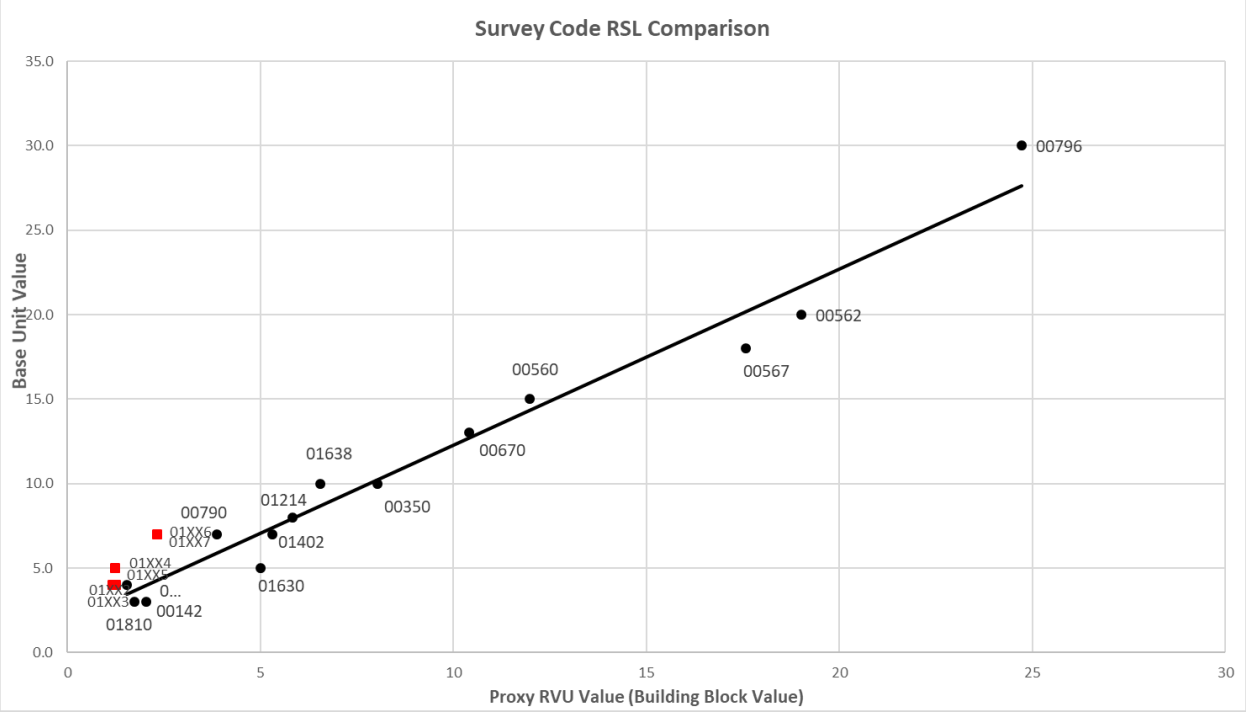
The expert panel believes that this higher recommended value for code 01939 is appropriate when compared to code 01940.

Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis

The RUC recently approved the BBM and RSL Regression Analysis. This supplemental tool to traditional RUC survey techniques is a way to compare relativity among anesthesia services. It is used to validate the presented recommendation. Using survey data and the RUC approved time packages, the expert panel calculated the BBM value known as a "proxy RVU." This value was plotted on the "Survey Code RSL Comparison Graph." This is a linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values ("proxy RVUs"). The proxy RVU for 01939 was plotted on the graph. The closer a point is to the regression line, the better the proxy RVU and the base unit align, regardless if the point is above or below the regression line.

The recommended value is supported when it was plotted on the RSL Regression Analysis Graph. The proxy RVU value for 01939 is plotted close to the graph with the base unit recommendation, indicating that the recommendation maintains appropriate ran order when compared to the other codes on the Anesthesia RSL.

The regression line tool developed by the Anesthesia Workgroup is a line of best fit, and by definition will have data points above and below the regression line. Two data points that are equidistant from the regression line, either above or below the line, would be equally supported by the model. In evaluating the plotted data points for the recommended base unit values, the expert panel believes the data points support the recommendations which are based on survey data and clinical expertise.



Anesthesia RSL and Surveyed Code 01939

CPT Code	Long Descriptor	Anesthesia Base Units	BBM Value
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3.0	1.735
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.0	1.857

00142	Anesthesia for procedures on eye; lens surgery	4.0	1.538
01939	Anesthesia for image guided destruction procedures by neurolytic agent on the spine and spinal cord; cervical or thoracic	4.0	1.23
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.0	4.772
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7.0	3.858
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.0	5.309
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.0	5.833
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.0	8.841
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.0	6.550
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.0	10.406
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.0	11.965
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.0	17.577
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20.0	19.006
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.0	24.719

Post-Induction Period Procedure Anesthesia (PIPPA)

PIPPA is a relative intensity methodology used by the RUC to validate anesthesia base unit values. It is important to remember that PIPPA only looks at the post-induction period and estimates of varying levels of intensity. PIPPA does not account for differences in intensity of induction of anesthesia (part of intra-service work), or any work done in the pre or post service period. Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels. Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another.

Conceptually, it may be considered the time for the surgeon to perform the procedure. The level of intensity and complexity during the PIPPA period is divided into five levels, or quintiles, each of which has its own descriptor. Survey respondents rate the percentage of the total PIPPA time that the typical patient falls under each of the quintiles. During its third five-year review, which was initiated in February 2005, the RUC assigned intensity values to each quintile. Intensity values do not appear on the RUC survey. The survey responses are used to determine a weighted

average of the combined PIPPA intensity/complexity value. PIPPA values do not determine base unit values, but may be used to validate the reasonableness of proposed values.

RUC Assigned PIPPA Intensity Values	
Level 1: Presenting problems are self-limited or minor. Straightforward medical decision-making and treatment.	0.031
Level 2: Problems are of low intensity. Medical decision-making and treatment of low complexity.	0.044
Level 3: Problems are of moderate severity. Medical decision making and treatment of moderate complexity.	0.055
Level 4: Problems are of moderate to high severity. Medical decision-making of moderate to high complexity and treatment of high complexity. Critically ill or critically injured patients.	0.070
Level 5: Problems are of high severity medical decision making and treatment of high complexity. Critically ill or critically injured patients.	0.090

The weighted average PIPPA for 01939 is 0.0437. PIPPA is used to validate recommendations and not establish recommended base unit values.

The weighted PIPPA intensity for 01939 is consistent with other codes of similar value on the anesthesia RSL.

Code	Descriptor	Base Unit	Weighted PIPPA Intensity	Level 1	Level 2	Level 3	Level 4	Level 5
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3	0.0406	58.02%	24.69%	7.89%	5.38%	4.02%
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3	0.0406	58.35%	24.03%	8.59%	4.66%	4.37%
01939	Anesthesia for image guided destruction procedures by neurolytic agent on the spine and spinal cord; cervical or thoracic	4	0.0437	47.28%	28.28%	12.50%	6.65%	5.30%
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5	0.0445	40.88%	30.58%	16.90%	7.01%	4.63%

Budget Neutrality

In drafting recommendations for this code family, the specialty society considered the impact of the recommendation on budget neutrality. Based on the presented base unit recommendations and utilization, there is a resulting negative impact on total base units (-0.47%) across the entire family.

The pattern of base units proposed provides the best balance between the survey responses, expert panel opinion regarding rank order within the family, and budget neutrality.

For time the specialty is recommending:

- Pre-Anesthesia
  - *Evaluation:* 10.5 minutes
  - *Equipment/Drug/Supple preparation:* 7 minutes
- Intra-op
  - *Induction:* 2 minutes
  - *Post-induction:* 15 minutes
- *Post-induction:* 9.5 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 01935 and 01936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Physician Anesthesiologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 112,872
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 112,872 Percentage 100%

Specialty Frequency Percentage

Specialty Frequency Percentage

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 37,624 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology	Frequency 37,624	Percentage	100.00%

Specialty	Frequency	Percentage

Specialty	Frequency	Percentage

Do many physicians perform this service across the United States? Yes

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:01940 Tracking Number: Original Specialty Recommended Base Unit Value: **4**
Presented Recommended Base Unit Value: 4
Global Period:XXX Current Base Unit Value: **NA** RUC Recommended Base Unit Value: **4**

CPT Descriptor: Anesthesia for image guided destruction procedures by neurolytic agent on the spine and spinal cord; lumbar or sacral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male with constant low back pain due to degenerative disc disease and facet arthropathy received insufficient relief with conservative treatments. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He undergoes radiofrequency neurotomy of the two medial branch nerves innervating the unilateral symptomatic facet joint.

Percentage of Survey Respondents who found Vignette to be Typical: 100.00%

Description of Pre-Service Work: A pre-procedure evaluation and targeted physical examination of the patient is performed. Review laboratory studies, ECG results, and imaging studies as necessary. Discuss with patient anesthetic technique to be used given the nature of the procedure and the requirements of the physician performing the procedure. Obtain informed consent. Set up anesthetic and drugs in preparation for the procedure and check anesthesia equipment, supplies, and monitors. A peripheral intravenous catheter is placed.

Description of Intra-Service Work: In the procedure room, monitoring is established and a presurgical review is performed. The patient is placed in the prone position with special care to avoid positioning injuries. Sufficient sedation and analgesia are provided to allow the patient to remain comfortable and cooperative with the procedure. Medications are titrated and the patient is monitored to preserve stable vital signs and adequate respiratory efforts throughout.

At the end of the procedure, the patient is turned supine and transferred to the postanesthetic care unit where a postanesthetic report is provided. Elements of the anesthesia care including vital signs (at least every five minutes), positioning, anesthesia procedures, medications, and significant events are personally documented in the anesthetic record.

Description of Post-Service Work: Appropriate analgesic and/or antiemetic are ordered for postprocedure discomfort, as necessary. Anesthesia equipment and medications are disposed of. A postoperative evaluation is made in the postanesthesia care unit to determine satisfactory recovery from anesthetic care and to determine whether any anesthetic-related complications have occurred. Any postanesthesia care is provided, as needed, in the postanesthesia care unit. The patient is discharged from the unit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021	
Presenter(s):	Neal Cohen, MD, Gordon Morewood, MD, Richard Rosenquist, MD	
Specialty Society(ies):	American Society of Anesthesiologists	
CPT Code:	01940	
Sample Size:	7404	**Resp n:** 41
Description of Sample:	Random Sample	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	20.00	400.00
Survey Base Unit Values:	3.00	4.00	**5.00**	7.00	20.00
Pre-Anesthesia Time:					
Pre-Service Evaluation	**3.00**	**6.00**	**11.00**	**15.00**	**35.00**
Equipment/Drug/Supply Preparation	**1.00**	**5.00**	**10.00**	**15.00**	**30.00**
Intra-op Anesthesia Time:					
Induction Period Procedure	1.00	6.00	**10.00**	15.00	30.00
Post-Induction Period Anesthesia	0.00	10.00	**15.00**	30.00	100.00
Post-Anesthesia Evaluation Time:			**10.00**		

SPECIALTY SOCIETY RECOMMENDED DATA

CPT Code: 01940	
	Specialty Recommended
Base Unit Value:	**4.00**
Pre-Anesthesia Time:	
Pre-Service Evaluation	**11.00**
Equipment/Drug/Supply Preparation	**7.00**
Intra-op Anesthesia Time:	
Induction Period Procedure	**2.00**
Pos-Induction Period Anesthesia	**15.00**
Post-Anesthesia Evaluation Time:	**10.00**

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
01630	XXX	5	RUC Time

CPT Descriptor Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00142	XXX	4	**RUC Time**

CPT Descriptor Anesthesia for procedures on eye; lens surgery

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization
CPT Descriptor 1				
MPC CPT Code 2	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization
CPT Descriptor 2				

Other Reference CPT Code	Global	Base Unit Value	Time Source
		0	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 36.5 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 26.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 01940	Top Key CPT Code: 01630	2nd Key CPT Code: 00142
Median Pre-Service Time - Evaluation	11.00	12.00	10.00
Median Pre-Service Time - Equipment/Supply Preparation	7.00	12.00	5.00
Median Intra-Service Time – Induction Period	2.00	15.00	5.00
Median Intra-Service Time – Post-Induction Period	15.00	90.00	25.00
Median Post-service Time	10.00	11.00	5.00
Median Total Time	**45.00**	**140.00**	**50.00**

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	53%	33%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	46%	47%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	20%	53%
Physical effort required	27%	20%	53%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	33%	60%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	36%	64%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	37%	54%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	46%	45%
Physical effort required	0%	36%	64%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	18%	82%

Post-Induction Period Procedure Anesthesia Time Allocation

	Survey Code Percentage of Time (%)	**Top Key** Percentage of Time (%)	**2nd Key** Percentage of Time (%)
Level 1 Problems are self-limited or minor; Straightforward medical decision making and treatment	46.49	40.88	67.83
Level 2 Problems are of low severity; Medical decision making and treatment of low complexity	28.12	30.58	18.42
Level 3 Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	12.34	16.90	5.68
Level 4 Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	6.66	7.01	4.14
Level 5 Problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	6.39	4.63	3.92
Total (must total 100%)	99.00%	101.00%	100.00%

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Society of Anesthesiologists (ASA) is pleased to submit anesthesia base unit recommendations for code 01940 *(Anesthesia for image guided destruction procedures by neurolytic agent on the spine and spinal cord; lumbar or sacral).*

Code	Descriptor	Jan RUC 2021 Recommendation	Rationale
01937	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic	4	25th
01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	4	25th
01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	4	Xwalk
01940	**Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral**	**4**	**25th**
01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	6	Xwalk
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	6	Xwalk

Background

CPT code 01940 was created in October 2020, along with the entire code family (0193701942) describing anesthesia for image-guided procedures on the spine. The code family replaces CPT code 01935 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic)* and 01936 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic).*

The new code family was created to provide more granularity for anesthesia services that are used for image-guided procedures on the spine after CPT code 01936 was flagged in 2017 for high volume growth and the RAW recommended that the codes be reviewed by CPT.

The approved methodology to identify the vignette for an anesthesia service is to base the typical patient off of the most common underlying procedure reported with the anesthesia code. Based on an analysis of the Medicare 5% file, the most common procedure billed with the anesthesia procedure code (01936), after add-on codes and ancillary codes were removed is:

64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

As approved by the RUC Research subcommittee, the vignette used in the survey was from the typical patient described by CPT code 64635.

Expert Panel Recommendation

ASA is recommending the survey 25th percentile of 4 base units for CPT code 01940.
For time we are recommending:

Time Period	Minutes	Source
Pre-Service Evaluation	11	Survey median
Equipment/Drug Supply Preparation	7	Time package: straightforward patient/straightforward anesthetic
Induction Period Procedure	2	Time package: straightforward patient/straightforward anesthetic
Post-Induction Period Anesthesia	15	Survey median
Post-Anesthesia Evaluation	10	Survey median

Survey Sample and Process

The survey data and recommendations are based upon a random sample of 7,404 physician anesthesiologist members of ASA. The surveying society convened an expert panel to review the survey data.

Recommendation Rationale

An expert panel of anesthesiologists was convened to consider the survey data and provide recommendations. In developing recommendations the expert panel considered survey data, key reference codes, the Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis; and Post-Induction Period Procedure Anesthesia (PIPPA).

Survey Data

The panel is recommending the survey 25th percentile of 4 anesthesia base units.

A total of 41 responses were received, 100% of respondents agreed the patient vignette was typical and the median experience in the past 12 months was 2.

The recommended value is a reduction in base units from the original CPT codes (01935 and 01936), which this new code family is replacing. The expert panel agreed this recommendation was appropriate and that it maintained appropriate rank order in the family.

Key Reference Codes

37% of survey respondents selected 01630 (*Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified*) valued at 5 base units as the top key reference service code.

- 93% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

27% of survey respondents selected 00142 (*Anesthesia for procedures on eye; lens surgery*) valued at 4 base units as the second key reference service code.

- 100% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

The expert panel concluded that the intensity/complexity measures supported their recommendation.

Comparison with Paired Spinal Code

The expert panel is recommending the survey 25th percentile base unit value of 4 for CPT code 01940. This value is lower than the paired spinal code 01939 that is used to report anesthesia for the same procedure, but in a different spinal region. CPT code 01939 is used for services performed in the cervical or thoracic region. Procedures performed in this region are inherently more complex and have higher associated risk.

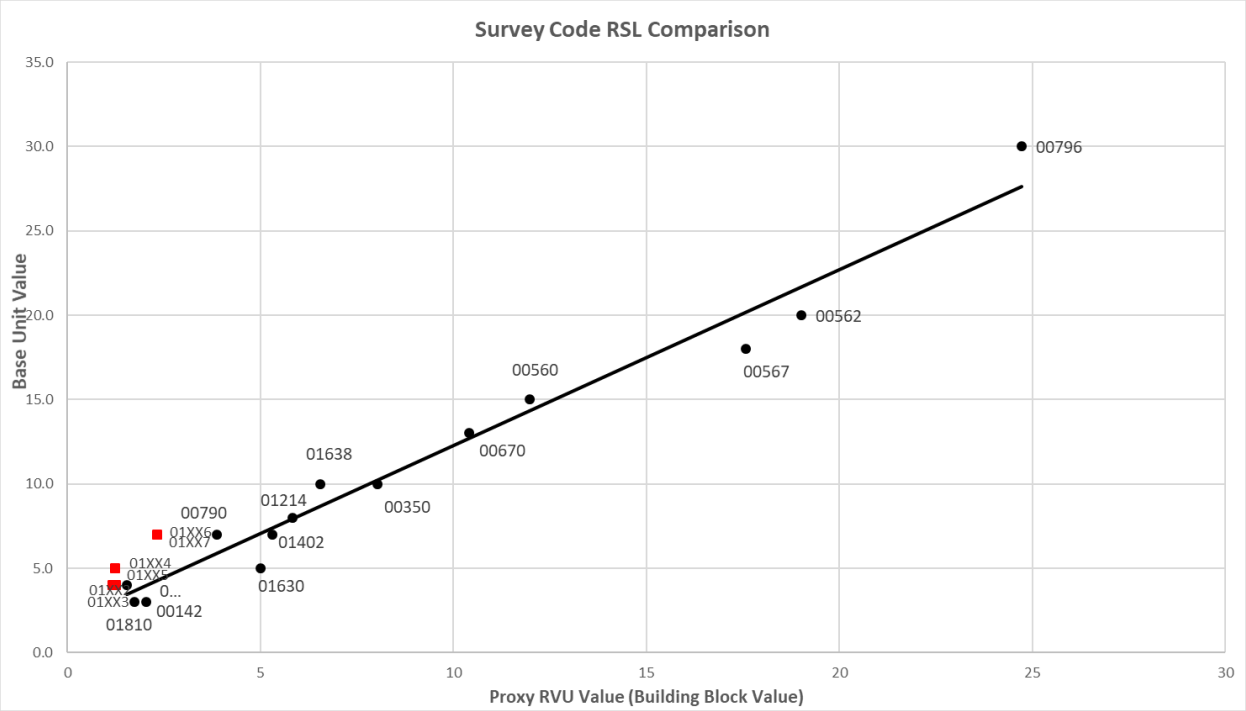
The expert panel believes that the lower recommended value for code 01940 is appropriate when compared to code 01939.

Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis

The RUC recently approved the BBM and RSL Regression Analysis. This supplemental tool to traditional RUC survey techniques is a way to compare relativity among anesthesia services. It is used to validate the presented recommendation. Using survey data and the RUC approved time packages, the expert panel calculated the BBM value known as a "proxy RVU." This value was plotted on the "Survey Code RSL Comparison Graph." This is a linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values ("proxy RVUs"). The proxy RVU for 01940 was plotted on the graph. The closer a point is to the regression line, the better the proxy RVU and the base unit align, regardless if the point is above or below the regression line.

The recommended value is supported when it was plotted on the RSL Regression Analysis Graph. The proxy RVU value for 01940 is plotted close to the graph with the base unit recommendation of 4 base units, indicating that the recommendation maintains appropriate rank order when compared to the other codes on the Anesthesia RSL.

The regression line tool developed by the Anesthesia Workgroup is a line of best fit, and by definition will have data points above and below the regression line. Two data points that are equidistant from the regression line, either above or below the line, would be equally supported by the model. In evaluating the plotted data points for the recommended base unit values, the expert panel believes the data points support the recommendations which are based on survey data and clinical expertise.



Anesthesia RSL and 01940

CPT Code	Long Descriptor	Anesthesia Base Units	BBM Value
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3.0	1.735
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.0	1.857
00142	Anesthesia for procedures on eye; lens surgery	4.0	1.538

01940	Anesthesia for image guided destruction procedures by neurolytic agent on the spine and spinal cord; lumbar or sacral	4.0	1.26
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.0	4.772
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7.0	3.858
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.0	5.309
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.0	5.833
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.0	8.841
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.0	6.550
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.0	10.406
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.0	11.965
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.0	17.577
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20.0	19.006
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.0	24.719

Post-Induction Period Procedure Anesthesia (PIPPA)

PIPPA is a relative intensity methodology used by the RUC to validate anesthesia base unit values. It is important to remember that PIPPA only looks at the post-induction period and estimates of varying levels of intensity. PIPPA does not account for differences in intensity of induction of anesthesia (part of intra-service work), or any work done in the pre or post service period. Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels. Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another.

Conceptually, it may be considered the time for the surgeon to perform the procedure. The level of intensity and complexity during the PIPPA period is divided into five levels, or quintiles, each of which has its own descriptor. Survey respondents rate the percentage of the total PIPPA time that the typical patient falls under each of the quintiles. During its third five-year review, which was initiated in February 2005, the RUC assigned intensity values to each quintile. Intensity values do not appear on the RUC survey. The survey responses are used to determine a weighted

average of the combined PIPPA intensity/complexity value. PIPPA values do not determine base unit values, but may be used to validate the reasonableness of proposed values.

RUC Assigned PIPPA Intensity Values	
Level 1: Presenting problems are self-limited or minor. Straightforward medical decision-making and treatment.	0.031
Level 2: Problems are of low intensity. Medical decision-making and treatment of low complexity.	0.044
Level 3: Problems are of moderate severity. Medical decision making and treatment of moderate complexity.	0.055
Level 4: Problems are of moderate to high severity. Medical decision-making of moderate to high complexity and treatment of high complexity. Critically ill or critically injured patients.	0.070
Level 5: Problems are of high severity medical decision making and treatment of high complexity. Critically ill or critically injured patients.	0.090

The weighted average PIPPA for 01940 is 0.0443. This value validates the recommendation of 4 base units in comparison with other codes on the Anesthesia RSL. PIPPA is used to validate recommendations and not establish recommended base unit values.

The weighted PIPPA intensity for 01940 is consistent with other codes of similar value on the anesthesia RSL. The expert panel believes the distribution of PIPPA, confirms the recommended value of 4 base units for 01940.

Code	Descriptor	Base Unit	Weighted PIPPA Intensity	Level 1	Level 2	Level 3	Level 4	Level 5
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3	0.0406	58.02%	24.69%	7.89%	5.38%	4.02%
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3	0.0406	58.35%	24.03%	8.59%	4.66%	4.37%
01940	Anesthesia for image guided destruction procedures by neurolytic agent on the spine and spinal cord; lumbar or sacral	4	0.0443	46.49%	28.12%	12.34%	6.66%	6.39%
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5	0.0445	40.88%	30.58%	16.90%	7.01%	4.63%

Budget Neutrality

In drafting recommendations for this code family, the specialty society considered the impact of the recommendation on budget neutrality. Based on the presented base unit recommendations and utilization, there is a resulting negative impact on total base units (-0.47%) across the entire family.

The pattern of base units proposed provides the best balance between the survey responses, expert panel opinion regarding rank order within the family, and budget neutrality.

In conclusion, ASA is recommending the survey 25th percentile of 4 anesthesia base units. For time the specialty is recommending:

- Pre-Anesthesia
  - *Evaluation:* 11 minutes
  - *Equipment/Drug/Supple preparation:* 7 minutes
- Intra-op
  - *Induction:* 2 minutes
  - *Post-induction:* 15 minutes
- *Post-induction:* 10 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 01935 and 01936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Physician Anesthesiologists How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 301,784
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 301,784 Percentage 100%

Specialty Frequency Percentage

Specialty Frequency Percentage

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100,595 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 100,595 Percentage 100.00%

Specialty Frequency Percentage

Specialty Frequency Percentage

Do many physicians perform this service across the United States? Yes

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:01941 Tracking Number: Original Specialty Recommended Base Unit Value: **7**
Presented Recommended Base Unit Value: 7
Global Period:XXX Current Base Unit Value: **NA** RUC Recommended Base Unit Value: **6**

CPT Descriptor: Anesthesia for image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) in the spine and spinal cord; cervical or thoracic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female develops sudden, severe mid-back pain after lifting her grandchild. Plain radiographs reveal an acute compression fracture with severe anterior wedging involving T10 and consequent new kyphosis. Pain persists despite a period of conservative care. After referral, percutaneous thoracic vertebral augmentation (and bone biopsy, if indicated) is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 97.87%

Description of Pre-Service Work: A pre-procedure evaluation and targeted physical examination of the patient is performed. Review laboratory studies, ECG results, and imaging studies as necessary. Discuss with patient anesthetic technique to be used given the nature of the procedure and the requirements of the physician performing the procedure. Obtain informed consent. Set up anesthetic and drugs in preparation for the procedure and check anesthesia equipment, supplies, and monitors. A peripheral intravenous catheter is placed.

Description of Intra-Service Work: In the procedure room, monitoring is established and a presurgical review is performed. General anesthesia is induced and the trachea intubated. After the airway is secured and the patient's vital signs are stable the patient is placed in the prone position with special care to avoid positioning injuries. The patient is placed in a prone position with special care to avoid positioning injuries to the eyes, cervical spine, peripheral nerves and/or soft tissues. Anesthesia care is provided, medications are titrated, and the patient is monitored and reassessed throughout the procedure.

At the end of the procedure, the patient is turned supine, "emerged," and extubated when medically appropriate. The patient is transferred to the postanesthetic care unit where a postanesthetic report is provided. Elements of the anesthesia care including vital signs (at least every five minutes), positioning, anesthesia procedures, medications, and significant events are personally documented in the anesthetic record.

Description of Post-Service Work: Appropriate analgesic and/or antiemetic are ordered for postprocedure discomfort, as necessary. Anesthesia equipment and medications are disposed of. A postoperative evaluation is made in the postanesthesia care unit to determine satisfactory recovery from anesthetic care and to determine whether any anesthetic-related complications have occurred. Any postanesthesia care is provided, as needed, in the postanesthesia care unit. The patient is discharged from the unit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021		
Presenter(s):	Neal Cohen, MD, Gordon Morewood, MD, Richard Rosenquist, MD		
Specialty Society(ies):	American Society of Anesthesiologists		
CPT Code:	01941		
Sample Size:	7404	**Resp n:** 47	

CPT Code: 01941

Description of Sample:	Random Sample				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	10.00	50.00
Survey Base Unit Values:	4.00	5.00	**7.00**	8.00	20.00
Pre-Anesthesia Time:					
Pre-Service Evaluation	**5.00**	**9.50**	**13.00**	**16.00**	**40.00**
Equipment/Drug/Supply Preparation	**2.00**	**6.00**	**10.00**	**15.00**	**30.00**
Intra-op Anesthesia Time:					
Induction Period Procedure	1.00	7.50	**10.00**	15.00	30.00
Post-Induction Period Anesthesia	5.00	13.50	**20.00**	52.50	135.00
Post-Anesthesia Evaluation Time:			**10.00**		

SPECIALTY SOCIETY RECOMMENDED DATA

CPT Code: 01941	
	Specialty Recommended
Base Unit Value:	**76.00**
Pre-Anesthesia Time:	
Pre-Service Evaluation	**13.00**
Equipment/Drug/Supply Preparation	**7.00**
Intra-op Anesthesia Time:	
Induction Period Procedure	**8.00**
Pos-Induction Period Anesthesia	**20.00**
Post-Anesthesia Evaluation Time:	**10.00**

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
01630	XXX	5	RUC Time

CPT Descriptor Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00670	XXX	13	**RUC Time**

CPT Descriptor Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization

CPT Descriptor 1

MPC CPT Code 2	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code	Global	Base Unit Value	Time Source
		0	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 23.4 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 14.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 01941	Top Key CPT Code: 01630	2nd Key CPT Code: 00670
Median Pre-Service Time - Evaluation	13.00	12.00	15.00
Median Pre-Service Time - Equipment/Supply Preparation	7.00	12.00	15.00
Median Intra-Service Time – Induction Period	8.00	15.00	15.00
Median Intra-Service Time – Post-Induction Period	20.00	90.00	180.50
Median Post-service Time	10.00	11.00	15.00
Median Total Time	**58.00**	**140.00**	**240.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	9%	55%	27%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	29%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	64%	18%
Physical effort required	9%	36%	55%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	18%	73%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	28%	29%	29%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	57%	29%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	57%	29%
Physical effort required	0%	57%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	43%	57%

Post-Induction Period Procedure Anesthesia Time Allocation

	Survey Code Percentage of Time (%)	**Top Key** Percentage of Time (%)	**2nd Key** Percentage of Time (%)
Level 1 Problems are self-limited or minor; Straightforward medical decision making and treatment	41.17	40.88	34.95
Level 2 Problems are of low severity; Medical decision making and treatment of low complexity	32.94	30.58	28.07
Level 3 Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	15.30	16.90	20.79
Level 4 Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	6.04	7.01	9.93
Level 5 Problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	4.55	4.63	6.26
Total (must total 100%)	100.00%	101.00%	100.00%

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Society of Anesthesiologists (ASA) is pleased to submit anesthesia base unit recommendations for code 01941 *(Anesthesia for image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) in the spine and spinal cord; cervical or thoracic).*

Code	Descriptor	Jan RUC 2021 Recommendation	Rationale
01937	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic	4	25th
01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	4	25th
01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	5	25th
01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	4	25th
01941	**Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic**	**6**	**Xwalk**
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	6	Xwalk

Background

CPT code 01941 was created in October 2020, along with the entire code family (01937-01942) describing anesthesia for image-guided procedures on the spine. The code family replaces CPT code 01935 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic)* and 01936 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic).*

The new code family was created to provide more granularity for anesthesia services that are used for image-guided procedures on the spine after CPT code 01936 was flagged in 2017 for high volume growth and the RAW recommended that the codes be reviewed by CPT.

The approved methodology to identify the vignette for an anesthesia service is to base the typical patient off of the most common underlying procedure reported with the anesthesia code. Based on an analysis of the Medicare 5% file, the most common procedure billed with anesthesia procedure (01936) for the same patient on the same day by a different provider, after add-on codes and ancillary codes were removed is:

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

As approved by the RUC Research subcommittee, the vignette used in the survey was from the typical patient described by CPT code 22513.

Expert Panel Recommendation

For time we are recommending:

Time Period	Minutes	Source
Pre-Service Evaluation	13	Survey median
Equipment/Drug Supply Preparation	7	Time package: straightforward patient/straightforward anesthetic
Induction Period Procedure	8	Time package: complex patient/straightforward anesthetic
Post-Induction Period Anesthesia	20	Survey median
Post-Anesthesia Evaluation	10	Survey median

Survey Sample and Process

The survey data and recommendations are based upon a random sample of 7,404 physician anesthesiologist members of ASA. The surveying society convened an expert panel to review the survey data.

Recommendation Rationale

An expert panel of anesthesiologists was convened to consider the survey data and provide recommendations. In developing recommendations the expert panel considered survey data, key reference codes, the Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis; and Post-Induction Period Procedure Anesthesia (PIPPA).

Survey Data

The panel is recommending the survey median of 7 anesthesia base units.

The survey was viewed as robust with 47 responses, 98% of respondents agreed with the typical patient vignette and the median experience in the past 12 months was 5.

The recommended value is an increase in from the original CPT codes (01935 and 01936), which this new code family is replacing. The expert panel agreed this increase was appropriate and maintained rank order in the family.

Key Reference Codes

23% of survey respondents selected 01630 (*Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified*) valued at 5 base units as the top key reference service code. 93% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

15% of survey respondents selected 00670 *(Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures))* valued at 13 base units as the second key reference service code. 91% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

The expert panel concluded that the intensity/complexity measures supported their recommendation of 7 base units for code 01941.

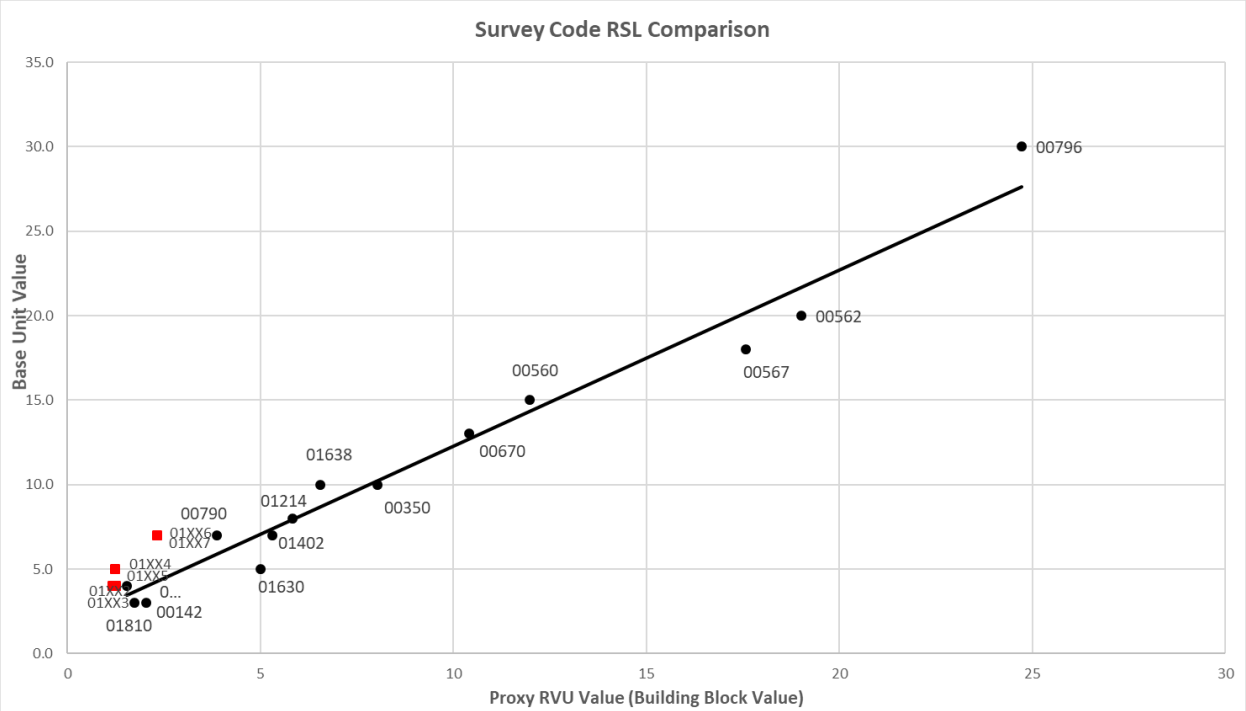
Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis

The RUC recently approved the BBM and RSL Regression Analysis. This supplemental tool to traditional RUC survey techniques is a way to compare relativity among anesthesia services. It is used to validate the presented recommendation. Using survey data and the RUC approved time packages, the expert panel calculated the BBM value known as a “proxy RVU.” This value was plotted on the “Survey Code RSL Comparison Graph.” This is a linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values

("proxy RVUs"). The proxy RVU for 01941 was plotted on the graph. The closer a point is to the regression line, the better the proxy RVU and the base unit align, regardless if the point is above or below the regression line.

The recommended is supported when it was plotted on the RSL Regression Analysis Graph. The proxy RVU value for 01941 is plotted close to the graph, indicating that the recommendation maintains appropriate ran order when compared to the other codes on the Anesthesia RSL.

The regression line tool developed by the Anesthesia Workgroup is a line of best fit, and by definition will have data points above and below the regression line. Two data points that are equidistant from the regression line, either above or below the line, would be equally supported by the model. In evaluating the plotted data points for the recommended base unit values, the expert panel believes the data points support the recommendations which are based on survey data and clinical expertise.



Anesthesia RSL and 01941

CPT Code	Long Descriptor	Anesthesia Base Units	BBM Value
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3.0	1.735
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.0	1.857
00142	Anesthesia for procedures on eye; lens surgery	4.0	1.538
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.0	4.772
01941	Anesthesia for image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) in the spine and spinal cord; cervical or thoracic	6.0	2.32
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise	7.0	3.858

	specified		
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.0	5.309
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.0	5.833
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.0	8.841
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.0	6.550
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.0	10.406
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.0	11.965
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.0	17.577
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20.0	19.006
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.0	24.719

Post-Induction Period Procedure Anesthesia (PIPPA)

PIPPA is a relative intensity methodology used by the RUC to validate anesthesia base unit values. It is important to remember that PIPPA only looks at the post-induction period and estimates of varying levels of intensity. PIPPA does not account for differences in intensity of induction of anesthesia (part of intra-service work), or any work done in the pre or post service period. Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels. Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another.

Conceptually, it may be considered the time for the surgeon to perform the procedure. The level of intensity and complexity during the PIPPA period is divided into five levels, or quintiles, each of which has its own descriptor. Survey respondents rate the percentage of the total PIPPA time that the typical patient falls under each of the quintiles. During its third five-year review, which was initiated in February 2005, the RUC assigned intensity values to each quintile. Intensity values do not appear on the RUC survey. The survey responses are used to determine a weighted average of the combined PIPPA intensity/complexity value. PIPPA values do not determine base unit values, but may be used to validate the reasonableness of proposed values.

RUC Assigned PIPPA Intensity Values	
Level 1: Presenting problems are self-limited or minor. Straightforward medical decision-making and treatment.	0.031
Level 2: Problems are of low intensity. Medical decision-making and treatment of low complexity.	0.044

Level 3: Problems are of moderate severity. Medical decision making and treatment of moderate complexity.	0.055
Level 4: Problems are of moderate to high severity. Medical decision-making of moderate to high complexity and treatment of high complexity. Critically ill or critically injured patients.	0.070
Level 5: Problems are of high severity medical decision making and treatment of high complexity. Critically ill or critically injured patients.	0.090

The weighted average PIPPA for 01941 is 0.0443. This value validates the recommendation of 7 base units in comparison with other codes on the Anesthesia RSL. PIPPA is used to validate recommendations and not establish recommended base unit values.

The weighted PIPPA intensity for 01941 is consistent with other codes of similar value on the anesthesia RSL. The expert panel believes the distribution of PIPPA, confirms the recommended value of 7 base units for 01941.

Code	Descriptor	Base Unit	Weighted PIPPA Intensity	Level 1	Level 2	Level 3	Level 4	Level 5
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5	0.0445	40.88%	30.58%	16.90%	7.01%	4.63%
01941	Anesthesia for image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) in the spine and spinal cord; cervical or thoracic	6	0.0443	41.17%	32.94%	15.30%	6.04%	4.55%
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7	0.0440	44.48%	28.78%	15.28%	5.94%	5.52%
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7	0.0444	42.20%	30.57%	15.24%	6.67%	5.32%
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8	0.0450	40.20%	30.62%	15.96%	8.04%	5.18%

Relativity within Code Family

In reviewing survey data and the supporting BBM value and regression analysis, the expert panel concluded that the relatively higher values for 01941 and 01942 were appropriate given the clinical complexity of the anesthesia procedure and the more complex typical patient.

CPT code 01941 and 01942 are used to report anesthesia for image guided neuromodulation or intravertebral procedures. The surveying society conducted an analysis detailing the services typically reported with the previous anesthesia codes (01935/01936) that would now be reported with codes 01941 and 01942. The society identified 22513 and 22514 as the most frequently reported underlying procedure with 01941 and 01942.

These procedures require a more complex anesthetic technique to protect the patients while in the prone position. This position takes extra care prior to the start of the procedure to ensure the airway is properly secured. During the procedure, the patient is unable to protect their own airway, causing the potential for significant complications and requires constant monitoring. Additionally, spinal procedures performed in the prone position cause additional

pressure points for the anesthetist to monitor throughout the procedure. These risks and added complexities exist for procedures performed on the upper and lower regions of the spine.

The complexity of the service, the added comorbidities of the typical patient, and the required constant monitoring of the patient in the prone position support the value of 6 base unit for CPT code 01941.

Budget Neutrality

In drafting recommendations for this code family, the specialty society considered the impact of the recommendation on budget neutrality. Based on the presented base unit recommendations and utilization, there is a resulting negative impact on total base units (-0.47%) across the entire family.

The pattern of base units proposed provides the best balance between the survey responses, expert panel opinion regarding rank order within the family, and budget neutrality.

For time the specialty is recommending:

- Pre-Anesthesia
  - *Evaluation:* 13 minutes
  - *Equipment/Drug/Supple preparation:* 7 minutes
- Intra-op
  - *Induction:* 8 minutes
  - *Post-induction:* 20 minutes
- *Post-induction:* 10 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 01935 and 01936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Physician Anesthesiologists How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 141,535
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 141,535 Percentage 100%

Specialty Frequency Percentage

Specialty Frequency Percentage

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 47,178 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 47,178 Percentage 100.00%

Specialty Frequency Percentage

Specialty Frequency Percentage

Do many physicians perform this service across the United States? Yes

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:01942 Tracking Number: Original Specialty Recommended Base Unit Value: **7**
Presented Recommended Base Unit Value: 6
Global Period:XXX Current Base Unit Value: **NA** RUC Recommended Base Unit Value: **6**

CPT Descriptor: Anesthesia for image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) in the spine and spinal cord; lumbar or sacral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female presents with severe, persistent low back pain and progressive spinal deformity secondary to osteoporotic vertebral collapse. Plain radiographs reveal an acute compression fracture of L3. Despite conservative medical management, pain persists. Percutaneous lumbar vertebral augmentation (and bone biopsy, if indicated) is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 95.92%

Description of Pre-Service Work: A pre-procedure evaluation and targeted physical examination of the patient is performed. Review laboratory studies, ECG results, and imaging studies as necessary. Discuss with patient anesthetic technique to be used given the nature of the procedure and the requirements of the physician performing the procedure. Obtain informed consent. Set up anesthetic and drugs in preparation for the procedure and check anesthesia equipment, supplies, and monitors. A peripheral intravenous catheter is placed.

Description of Intra-Service Work: In the procedure room, monitoring is established and a presurgical review is performed. General anesthesia is induced and the trachea intubated. After the airway is secured and the patient's vital signs are stable the patient is placed in the prone position with special care to avoid positioning injuries. The patient is placed in a prone position with special care to avoid positioning injuries to the eyes, cervical spine, peripheral nerves and/or soft tissues. Anesthesia care is provided, medications are titrated, and the patient is monitored and reassessed throughout the procedure.

At the end of the procedure, the patient is turned supine, "emerged," and extubated when medically appropriate. The patient is transferred to the postanesthetic care unit where a postanesthetic report is provided. Elements of the anesthesia care including vital signs (at least every five minutes), positioning, anesthesia procedures, medications, and significant events are personally documented in the anesthetic record.

Description of Post-Service Work: Appropriate analgesic and/or antiemetic are ordered for postprocedure discomfort, as necessary. Anesthesia equipment and medications are disposed of. A postoperative evaluation is made in the postanesthesia care unit to determine satisfactory recovery from anesthetic care and to determine whether any anesthetic-related complications have occurred. Any postanesthesia care is provided, as needed, in the postanesthesia care unit. The patient is discharged from the unit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021	
Presenter(s):	Neal Cohen, MD, Gordon Morewood, MD, Richard Rosenquist, MD	
Specialty Society(ies):	American Society of Anesthesiologists	
CPT Code:	01942	
Sample Size:	7404	**Resp n:** 49

CPT Code: 01942

Description of Sample:	Random Sample				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	12.00	300.00
Survey Base Unit Values:	4.00	5.00	**7.00**	8.00	20.00
Pre-Anesthesia Time:					
Pre-Service Evaluation	**5.00**	**10.00**	**13.00**	**16.00**	**40.00**
Equipment/Drug/Supply Preparation	**2.00**	**6.00**	**10.00**	**15.00**	**30.00**
Intra-op Anesthesia Time:					
Induction Period Procedure	1.00	7.00	**10.00**	15.00	30.00
Post-Induction Period Anesthesia	5.00	13.00	**20.00**	60.00	120.00
Post-Anesthesia Evaluation Time:			**10.00**		

SPECIALTY SOCIETY RECOMMENDED DATA

CPT Code: 01942	
	Specialty Recommended
Base Unit Value:	**6.00**
Pre-Anesthesia Time:	
Pre-Service Evaluation	**13.00**
Equipment/Drug/Supply Preparation	**7.00**
Intra-op Anesthesia Time:	
Induction Period Procedure	**8.00**
Pos-Induction Period Anesthesia	**20.00**
Post-Anesthesia Evaluation Time:	**10.00**

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
01630	XXX	5	RUC Time

CPT Descriptor Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value	Time Source
00670	XXX	13	**RUC Time**

CPT Descriptor Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization

CPT Descriptor 1

MPC CPT Code 2	Global	Base Unit Value	Time Source	Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code	Global	Base Unit Value	Time Source
		0	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 23.4 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 14.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 01942	Top Key CPT Code: 01630	2nd Key CPT Code: 00670
Median Pre-Service Time - Evaluation	13.00	12.00	15.00
Median Pre-Service Time - Equipment/Supply Preparation	7.00	12.00	15.00
Median Intra-Service Time – Induction Period	8.00	15.00	15.00
Median Intra-Service Time – Post-Induction Period	20.00	90.00	180.50
Median Post-service Time	10.00	11.00	15.00
Median Total Time	**58.00**	**140.00**	**240.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	45%	36%	18%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	64%	36%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	55%	27%
Physical effort required	9%	36%	55%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	27%	73%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	43%	29%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	28%	29%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	43%	43%
Physical effort required	0%	57%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	29%	71%

Post-Induction Period Procedure Anesthesia Time Allocation

	Survey Code Percentage of Time (%)	**Top Key** Percentage of Time (%)	**2nd Key** Percentage of Time (%)
Level 1 Problems are self-limited or minor; Straightforward medical decision making and treatment	39.90	40.88	34.95
Level 2 Problems are of low severity; Medical decision making and treatment of low complexity	33.35	30.58	28.07
Level 3 Problems are of moderate severity; Medical decision making of moderate complexity and treatment of high complexity	15.49	16.90	20.79
Level 4 Problems are moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity	6.22	7.01	9.93
Level 5 Problems are of high severity; Medical decision making and treatment of high complexity; Critically ill or critically injured patient	5.04	4.63	6.26
Total (must total 100%)	99.00%	101.00%	100.00%

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Society of Anesthesiologists (ASA) is pleased to submit anesthesia base unit recommendations for code 01942 *(Anesthesia for image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) in the spine and spinal cord; lumbar or sacral).*

Code	Descriptor	Jan RUC 2021 Recommendation	Rationale
01937	Anesthesia for image guided injection, drainage or aspiration procedures on the spine and spinal cord; cervical or thoracic	4	25th
01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	4	25th
01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	4	Xwalk
01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	4	25th
01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic)	6	Xwalk
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral)	6	Xwalk

Background

CPT code 01942 was created in October 2020, along with the entire code family (01937-01942) describing anesthesia for image-guided procedures on the spine. The code family replaces CPT code 01935 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic)* and 01936 (*Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic).*

The new code family was created to provide more granularity for anesthesia services that are used for image-guided procedures on the spine after CPT code 01936 was flagged in 2017 for high volume growth and the RAW recommended that the codes be reviewed by CPT.

The approved methodology to identify the vignette for an anesthesia service is to base the typical patient off of the most common underlying procedure reported with the anesthesia code. Based on an analysis of the Medicare 5% file, the most common procedure billed with the underlying anesthesia procedure (01936), after add-on codes and ancillary codes were removed is:

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

As approved by the RUC Research subcommittee, the vignette used in the survey was from the typical patient described by CPT code 22514.

Expert Panel Recommendation

Time Period	Minutes	Source

Pre-Service Evaluation	13	Survey median
Equipment/Drug Supply Preparation	7	Time package: straightforward patient/straightforward anesthetic
Induction Period Procedure	8	Time package: complex patient/straightforward anesthetic
Post-Induction Period Anesthesia	20	Survey median
Post-Anesthesia Evaluation	10	Survey median

Survey Sample and Process

The survey data and recommendations are based upon a random sample of 7,404 physician anesthesiologist members of ASA. The surveying society convened an expert panel to review the survey data.

Recommendation Rationale

An expert panel of anesthesiologists was convened to consider the survey data and provide recommendations. In developing recommendations the expert panel considered survey data, key reference codes, the Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis; and Post-Induction Period Procedure Anesthesia (PIPPA).

Survey Data

The panel is recommending the survey median of 7 anesthesia base units.

A total of 49 responses were received, 96% of respondents agreed that the patient vignette was typical and the median experience in the past 12 months was 5.

The recommended value is an increase in from the original CPT codes (01935 and 01936) for which this new code family is replacing. The expert panel agreed this increase was appropriate and maintained rank order in the family.

Key Reference Codes

22% of survey respondents selected 01630 (*Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified*) valued at 5 base units as the top key reference service code. 100% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

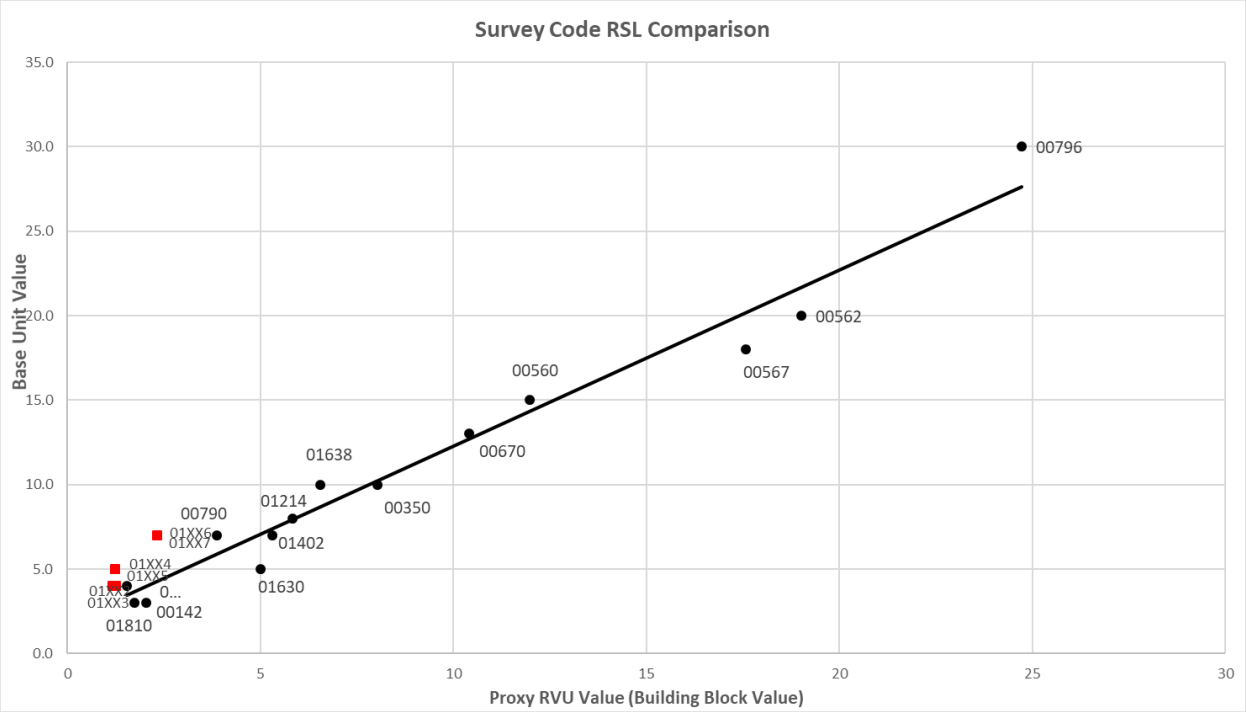
14% of survey respondents selected 00670 *(Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures))* valued at 13 base units as the second key reference service code. 86% of these respondents rated the surveyed code to be identical, somewhat more, or much more in overall intensity and complexity compared with the selected reference code.

Building Block Methodology (BBM) and Reference Service List (RSL) Regression Analysis

The RUC recently approved the BBM and RSL Regression Analysis. This supplemental tool to traditional RUC survey techniques is a way to compare relativity among anesthesia services. It is used to validate the presented recommendation. Using survey data and the RUC approved time packages, the expert panel calculated the BBM value known as a "proxy RVU." This value was plotted on the "Survey Code RSL Comparison Graph." This is a linear regression analysis of anesthesia codes on the RSL that plotted base unit values against anesthesia code building block values ("proxy RVUs"). The proxy RVU for 01942 was plotted on the graph. The closer a point is to the regression line, the better the proxy RVU and the base unit align, regardless if the point is above or below the regression line.

The recommended value was supported when it was plotted on the RSL Regression Analysis Graph. The proxy RVU value for 01942 is plotted close to the graph, indicating that the recommendation maintains appropriate ran order when compared to the other codes on the Anesthesia RSL.

The regression line tool developed by the Anesthesia Workgroup is a line of best fit, and by definition will have data points above and below the regression line. Two data points that are equidistant from the regression line, either above or below the line, would be equally supported by the model. In evaluating the plotted data points for the recommended base unit values, the expert panel believes the data points support the recommendations which are based on survey data and clinical expertise.



Anesthesia RSL & 01942

CPT Code	Long Descriptor	Anesthesia Base Units	BBM Value
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3.0	1.735
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3.0	1.857
00142	Anesthesia for procedures on eye; lens surgery	4.0	1.538
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5.0	4.772
01942	Anesthesia for image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) in the spine and spinal cord; lumbar or sacral	6.0	2.32
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7.0	3.858
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7.0	5.309

01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8.0	5.833
00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10.0	8.841
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10.0	6.550
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13.0	10.406
00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15.0	11.965
00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18.0	17.577
00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20.0	19.006
00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30.0	24.719

Post-Induction Period Procedure Anesthesia (PIPPA)

PIPPA is a relative intensity methodology used by the RUC to validate anesthesia base unit values. It is important to remember that PIPPA only looks at the post-induction period and estimates of varying levels of intensity. PIPPA does not account for differences in intensity of induction of anesthesia (part of intra-service work), or any work done in the pre or post service period. Survey respondents are asked to allocate the post-induction anesthesia time to five different intensity levels. Without a measure of the intensity of the post-induction period, all anesthesia procedures would be valued at the same intensity for this period based upon time units, which do not vary in intensity from one procedure to another.

Conceptually, it may be considered the time for the surgeon to perform the procedure. The level of intensity and complexity during the PIPPA period is divided into five levels, or quintiles, each of which has its own descriptor. Survey respondents rate the percentage of the total PIPPA time that the typical patient falls under each of the quintiles. During its third five-year review, which was initiated in February 2005, the RUC assigned intensity values to each quintile. Intensity values do not appear on the RUC survey. The survey responses are used to determine a weighted average of the combined PIPPA intensity/complexity value. PIPPA values do not determine base unit values, but may be used to validate the reasonableness of proposed values.

RUC Assigned PIPPA Intensity Values	
Level 1: Presenting problems are self-limited or minor. Straightforward medical decision-making and treatment.	0.031
Level 2: Problems are of low intensity. Medical decision-making and treatment of low complexity.	0.044
Level 3: Problems are of moderate severity. Medical decision making and treatment of moderate complexity.	0.055
Level 4: Problems are of moderate to high severity. Medical decision-making of moderate to high complexity and treatment of high	0.070

complexity. Critically ill or critically injured patients.	
Level 5: Problems are of high severity medical decision making and treatment of high complexity. Critically ill or critically injured patients.	0.090

The weighted average PIPPA for 01942 is 0.0447. This value validates the recommendation of 7 base units in comparison with other codes on the Anesthesia RSL. PIPPA is used to validate recommendations and not establish recommended base unit values.

The weighted PIPPA intensity for 01942 is consistent with other codes of similar value on the anesthesia RSL. The expert panel believes the distribution of PIPPA, confirms the recommended value of 7 base units for 01942.

Code	Descriptor	Base Unit	Weighted PIPPA Intensity	Level 1	Level 2	Level 3	Level 4	Level 5
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5	0.0445	40.88%	30.58%	16.90%	7.01%	4.63%
01942	Anesthesia for image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) in the spine and spinal cord; lumbar or sacral	6	0.0447	39.90%	33.35%	15.49%	6.22%	5.04%
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7	0.0440	44.48%	28.78%	15.28%	5.94%	5.52%
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7	0.0444	42.20%	30.57%	15.24%	6.67%	5.32%
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8	0.0450	40.20%	30.62%	15.96%	8.04%	5.18%

Relativity within Code Family

In reviewing survey data and the supporting BBM value and regression analysis, the expert panel concluded that the relatively higher values for 01941 and 01942 were appropriate given the clinical complexity of the anesthesia procedure and the more complex typical patient.

CPT code 01941 and 01942 are used to report anesthesia for image guided neuromodulation or intravertebral procedures. The surveying society conducted an analysis detailing the services typically reported with the previous anesthesia codes (01935/01936) that would now be reported with codes 01941 and 01942. The society identified 22513 and 22514 as the most frequently reported underlying procedure with 01941 and 01942.

These procedures require a more complex anesthetic technique to protect the patients while in the prone position. This position takes extra care prior to the start of the procedure to ensure the airway is properly secured. During the procedure, the patient is unable to protect their own airway, causing the potential for significant complications and requires constant monitoring. Additionally, spinal procedures performed in the prone position cause additional pressure points for the anesthetist to monitor throughout the procedure. These risks and added complexities exist for procedures performed on the upper and lower regions of the spine.

The complexity of the service, the added comorbidities of the typical patient, and the required constant monitoring of the patient in the prone position support 6 base unit recommendation for CPT code 01942.

Budget Neutrality

In drafting recommendations for this code family, the specialty society considered the impact of the recommendation on budget neutrality. Based on the presented base unit recommendations and utilization, there is a resulting negative impact on total base units (-0.47%) across the entire family.

The pattern of base units proposed provides the best balance between the survey responses, expert panel opinion regarding rank order within the family, and budget neutrality.

- Pre-Anesthesia
  - *Evaluation:* 13 minutes
  - *Equipment/Drug/Supple preparation:* 7 minutes
- Intra-op
  - *Induction:* 8 minutes
  - *Post-induction:* 20 minutes
- *Post-induction:* 10 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 01935 and 01936

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Physician Anesthesiologists How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 141,535
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 141,535 Percentage 100%

Specialty Frequency Percentage

Specialty Frequency Percentage

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 47,178 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Analysis of Medicare 5% Carrier File (2019) and RUC database (2020, V.2)

Specialty Anesthesiology Frequency 47,178 Percentage 100.00%

Specialty Frequency Percentage

Specialty Frequency Percentage

Do many physicians perform this service across the United States? Yes

SS Rec Summary

ISSUE: Anesthesia for Image Guided Procedures on the Spine

TAB: 4

Source	CPT	DESC	Resp	Anesthesia Base Unit Value					Total	Pre-Anesthesia Time										Intra-op Anesthesia Time										Post-Anesthesia Evaluation	Post-Induction Anesthesia Time-Intensity Allocation					
										Patient Evaluation					Equipment/Drug/Supply Preparation					Induction Period					Post-Induction Period											
				MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	POST	Level 1	Level 2	Level 3	Level 4	Level 5	Total
1st REF	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified				5.00			140			12					12					15					90			11	40.88%	30.58%	16.90%	7.01%	4.63%	100.00%
2nd REF	00142	Anesthesia for procedures on eye; lens surgery				4.00			50			10					5					5					25			5	67.83%	18.42%	5.68%	4.14%	3.92%	100.00%
CURRENT	01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic				5.00			90			20										55								15						
CURRENT	01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic				5.00			115			30										70								15						
SVY	01937	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic	41	2.00	4.00	5.00	6.00	10.00	50	4	8	10	15	30	1	5	9	15	30	1	6	8	15	25	0	10	15	20	100	8	52.95%	24.68%	10.63%	5.59%	6.15%	100%
REC	01937	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic				4.00			42			10					7					2					15			8						0%

Source	CPT	DESC	Resp	Anesthesia Base Unit Value					Total	Pre-Anesthesia Time										Intra-op Anesthesia Time										Post-Anesthesia Evaluation	Post-Induction Anesthesia Time-Intensity Allocation					
										Patient Evaluation					Equipment/Drug/Supply Preparation					Induction Period					Post-Induction Period											
				MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	POST	Level 1	Level 2	Level 3	Level 4	Level 5	Total
1st REF	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified				5.00			140			12					12					15					90			11	40.88%	30.58%	16.90%	7.01%	4.63%	100.00%
2nd REF	00142	Anesthesia for procedures on eye; lens surgery				4.00			50			10					5					5					25			5	67.83%	18.42%	5.68%	4.14%	3.92%	100.00%
CURRENT	01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic				5.00			90			20										55								15						
CURRENT	01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic				5.00			115			30										70								15						
SVY	01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	44	2.00	4.00	5.00	5.00	10.00	50	3	6	10	15	53	1	5	8	13	30	1	6	9	14	25	0	10	15	21	90	8	55.50%	25.52%	9.68%	4.45%	4.84%	100%
REC	01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral				4.00			42			10					7					2					15			8						0%

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK
15					Anesthesia Base Unit Value					Total	Pre-Anesthesia Time										Intra-op Anesthesia Time										Post-Anesthesia Evaluation	Post-Induction Anesthesia Time-Intensity Allocation					
16											Patient Evaluation					Equipment/Drug/Supply Preparation					Induction Period					Post-Induction Period										
17	Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	POST	Level 1	Level 2	Level 3	Level 4	Level 5	Total
35					Anesthesia Base Unit Value					Total	Pre-Anesthesia Time										Intra-op Anesthesia Time										Post-Anesthesia Evaluation	Post-Induction Anesthesia Time-Intensity Allocation					
36											Patient Evaluation					Equipment/Drug/Supply Preparation					Induction Period					Post-Induction Period										
37	Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	POST	Level 1	Level 2	Level 3	Level 4	Level 5	Total
38	1st REF	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified				5.00			140			12					12						15					90			11	40.88%	30.58%	16.90%	7.01%	4.63%	100.00%
39	2nd REF	00142	Anesthesia for procedures on eye; lens surgery				4.00			50			10					5						5					25			5	67.83%	18.42%	5.68%	4.14%	3.92%	100.00%
40	CURRENT	01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic				5.00			90			20											55								15						
41	CURRENT	01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic				5.00			115			30											70								15						
42	SVY	01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	40	3.00	5.00	5.00	7.00	20.00	55	4	8	11	15	35	1	6	10	15	30	1	6	10	15	30	0	10	15	30	110	10	47.28%	28.28%	12.50%	6.65%	5.30%	100%
43	REC	01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic				4.00			45			11					7						2					15			10						0%
44																																					
45					Anesthesia Base Unit Value					Total	Pre-Anesthesia Time										Intra-op Anesthesia Time										Post-Anesthesia Evaluation	Post-Induction Anesthesia Time-Intensity Allocation					
46											Patient Evaluation					Equipment/Drug/Supply Preparation					Induction Period					Post-Induction Period										
47	Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	POST	Level 1	Level 2	Level 3	Level 4	Level 5	Total
48	1st REF	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified				5.00			140			12					12						15					90			11	40.88%	30.58%	16.90%	7.01%	4.63%	100.00%
49	2nd REF	00142	Anesthesia for procedures on eye; lens surgery				4.00			50			10					5						5					25			5	67.83%	18.42%	5.68%	4.14%	3.92%	100.00%
50	CURRENT	01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic				5.00			90			20											55								15						
51	CURRENT	01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic				5.00			115			30											70								15						
52	SVY	01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	41	3.00	4.00	5.00	7.00	20.00	56	3	6	11	15	35	1	5	10	15	30	1	6	10	15	30	0	10	15	30	100	10	46.49%	28.12%	12.34%	6.66%	6.39%	100%
53	REC	01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral				4.00			45			11					7						2					15			10						0%
54																																					
55											Pre-Anesthesia Time										Intra-op Anesthesia Time																

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK
15					Anesthesia Base Unit Value					Total	Pre-Anesthesia Time										Intra-op Anesthesia Time										Post-Anesthesia Evaluation	Post-Induction Anesthesia Time-Intensity Allocation					
16											Patient Evaluation					Equipment/Drug/Supply Preparation					Induction Period					Post-Induction Period										
17	Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	POST	Level 1	Level 2	Level 3	Level 4	Level 5	Total
56											Patient Evaluation					Equipment/Drug/Supply Preparation					Induction Period					Post-Induction Period					Post-Anesthesia Evaluation						
57	Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	POST	Level 1	Level 2	Level 3	Level 4	Level 5	Total
58	1st REF	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified				5.00			140			12					12						15					90		11	40.88%	30.58%	16.90%	7.01%	4.63%	100.00%
59	2nd REF	00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)				13.00			241			15					15						15					181		15	34.95%	28.07%	20.79%	9.93%	6.26%	100.00%
60	CURRENT	01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic				5.00			90			20											55							15						
61	CURRENT	01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic				5.00			115			30											70							15						
62	SVY	01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	47	4.00	5.00	7.00	8.00	20.00	63	5	10	13	16	40	2	6	10	15	30	1	8	10	15	30	5	14	20	53	135	10	41.17%	32.94%	15.30%	6.04%	4.55%	100%
63	REC	01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic				6.00			58			13					7						8					20		10						0%
64	XWALK	00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)				6.00			100			15					10						65							10						
65																																					
66											Pre-Anesthesia Time										Intra-op Anesthesia Time										Post-Anesthesia Evaluation						
67											Patient Evaluation					Equipment/Drug/Supply Preparation					Induction Period					Post-Induction Period										
68	Source	CPT	DESC	Resp	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX	POST	Level 1	Level 2	Level 3	Level 4	Level 5	Total
69	1st REF	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified				5.00			140			12					12						15					90		11	40.88%	30.58%	16.90%	7.01%	4.63%	100.00%
70	2nd REF	00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)				13.00			241			15					15						15					181		15	34.95%	28.07%	20.79%	9.93%	6.26%	100.00%
71	CURRENT	01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic				5.00			90			20											55							15						
72	CURRENT	01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic				5.00			115			30											70							15						
73	SVY	01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	49	4.00	5.00	7.00	8.00	20.00	63	5	10	13	16	40	2	6	10	15	30	1	7	10	15	30	5	13	20	60	120	10	39.90%	33.35%	15.49%	6.22%	5.04%	100%
74	REC	01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral				6.00			58			13					7						8					20		10						0%
75	XWALK	00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)				6.00			100			15					10						65							10						

Build Block Methodology Calculations and Anesthesia Reference Service Comparison

ISSUE: Anesthesia Services for Image-Guided Spinal Procedures

TAB: 4

						Pre-Anesthesia Period				
						1A. Evaluation of the patient prior to the beginning of reportable anesthesia time				
			NOTE: The **Anesthesia Base Unit Value** comes from the 2019 Medicare Physician Fee Schedule; the **Building Block (BB) Value** is calculated using the methodology approved by the Anesthesia Workgroup and the RUC. At the request of the Anesthesia Workgroup this value was calculated with PIPPA (methdology approved by the RUC) and without PIPPA.							
Survey Date	**Source**	**CPT**	**Descriptor**	**Anesthesia Base Unit**	**BB Value w/ PIPPA***	**Min**	**25th**	**Median**	**75th**	**Max**
Apr-19	RUC	00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	3	**1.735**	1	6	8	10	30
Apr-19	CMS/Other	01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand	3	**1.857**	1	7	10	14	30
Apr-19	RUC	00142	Anesthesia for procedures on eye; lens surgery	4	**1.538**	1	5	10	11.75	32
Jan-21	RUC	01937	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic	4	**1.188**	4	8	10	15	30
Jan-21	RUC	01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	4	**1.175**	3	6	10	15	53
Jan-21	RUC	01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	4	**1.263**	3	6	11	15	35
Jan-21	RUC	01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	5	**1.229**	4	7.5	10.5	15	35

Apr-19	CMS/Other	01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified	5	**4.772**	1	9.25	12	16	43
Jan-21	RUC	01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	7	**2.316**	5	9.5	13	16	40
Jan-20	RUC	01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	7	**2.324**	5	10	13	16	40
Apr-19	CMS/Other	00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified	7	**3.858**	1	9	10	15	35
Apr-19	CMS/Other	01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	7	**5.309**	1	10	15	19.5	43
Apr-19	RUC	01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	8	**5.833**	1	10	15	20	39
Apr-19	CMS/Other	00350	Anesthesia for procedures on major vessels of neck; not otherwise specified	10	**8.841**	1	11.75	15	20	60
Apr-19	CMS/Other	01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	10	**6.550**	1	10	15	19	43
Apr-19	CMS/Other	00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	13	**10.406**	1	10	15	20	45
Apr-19	CMS/Other	00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	15	**11.965**	1	15	20	28	60
Oct-19	RUC	00567	Anesthesia for direct coronary artery bypass grafting; with pump oxygenator	18	**17.577**	5	19	25	32	90
Apr-19	RUC	00562	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 year or older, for all noncoronary bypass procedures (eg, valve procedures) or for re-operation for coronary bypass more than 1 month after original operation	20	**19.006**	1	16	20	30	60
Apr-19	CMS/Other	00796	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; liver transplant (recipient)	30	**24.719**	1	15	23	45	90
	* Building Block (BB) Value is calculated using the methodology approved by the Anesthesia Workgroup and the RUC.									

FOR REFERENCE ONLY

Equipment, Drug, Supply Prep	
Internal Medicine	7
Complex Patient/Straightforward Anesthetic	15
Straightforward Patient/Complex Anesthetic	12
Complex Patient/Complex Anesthetic	25

Induction Period	
Straightforward Patient/Straightforward Anesthetic	2
Complex Patient/Straightforward Anesthetic	8
Straightforward Patient/Complex Anesthetic	5
Complex Patient/Complex Anesthetic	15

PIPPA Intensity Factors				
Level 1	Level 2	Level 3	Level 4	Level 5
0.031	0.044	0.055	0.070	0.096

						Intra-op Anesthesia Period									
1B. Equipment and Supply preparation						**1C. Induction period**						**1D. Post-induction period**			
Straightforward Patient/Straightforward Anesthetic= 7 minutes Complex Patient/Straightforward Anesthetic= 15 minutes Straightforward Patient/Complex Anesthetic= 12 minutes Complex Patient/Complex Anesthetic= 25 minutes						Straightforward Patient/Straightforward Anesthetic= 2 minutes Complex Patient/Straightforward Anesthetic= 8 minutes Straightforward Patient/Complex Anesthetic= 5 minutes Complex Patient/Complex Anesthetic= 15 minutes									
Min	**25th**	**Median**	**75th**	**Max**	**Time Package Selected (select from drop-down)**	**Min**	**25th**	**Median**	**75th**	**Max**	**Time Package Selected**	**Min**	**25th**	**Median**	**75th**
1	5	7	10	20	Straightforward Patient/Stra	0	5	6	10	36	ward Patient/Straightforward	1	20	29.5	41.25
1	6	10	14	25	Straightforward Patient/Stra	1	5	9.5	12	33	ward Patient/Straightforward	1	20	30	49.75
0	4	5	10	20	Straightforward Patient/Stra	0	4	5	8	30	Straightforward Patient/Straig	0	15	25	37
1	5	9	15	30	Straightforward Patient/Stra	1	6	8	15	25	Straightforward Patient/Straig	0	10	15	20
1	5	8	12.8	30	Straightforward Patient/Stra	1	6	9	14.25	25	Straightforward Patient/Straig	0	9.5	15	20.5
1	5	10	15	30	Straightforward Patient/Stra	1	6	10	15	30	Straightforward Patient/Straig	0	10	15	30
1	5.75	10	15	30	Straightforward Patient/Stra	1	6	10	15	30	Straightforward Patient/Straig	0	10	15	30

1	9	12	15	54	Straightforward Patient/Stra	1	10	15	20	59	rward Patient/Straightforward	1	60	90	131
2	6	10	15	30	Straightforward Patient/Stra	1	7.5	10	15	30	ex Patient/Straightforward Ane	5	13.5	20	52.5
2	6	10	15	30	Straightforward Patient/Stra	1	7	10	15	30	ex Patient/Straightforward Ane	5	13	20	60
1	7	10	15	36	Straightforward Patient/Stra	1	7.25	10	15	31	tforward Patient/Complex Ane	1	41.5	67.5	120
1	9.25	14	19	54	Straightforward Patient/Con	1	10	15	18	59	tforward Patient/Complex Ane	1	60	96	122.25
1	10	13.5	16.5	43	Straightforward Patient/Con	1	10	15	18.5	46	tforward Patient/Complex Ane	1	60	106	135
1	10	15	20	30	Complex Patient/Straightfor	1	9	15	22.25	40	mplex Patient/Complex Anesth	1	75	120	150
1	10	15	19	54	Straightforward Patient/Con	1	10	15	21	59	tforward Patient/Complex Ane	1	67.5	120	151
1	10	15	22	1215	Complex Patient/Straightfor	1	10	15	25.25	50	ex Patient/Straightforward Ane	1	120	180.5	241.5
1	15	25	30.5	60	Complex Patient/Complex A	1	13	20	31.5	60	mplex Patient/Complex Anesth	1	109.5	152	240
0	20	30	40	75	plex Patient/Complex Anesth	0	18	30	45	60	mplex Patient/Complex Anesth	0	200	240	320
1	18	27	39.3	60	Complex Patient/Complex A	1	17.5	30	45.5	66	mplex Patient/Complex Anesth	1	200	258.5	347.75
1	16	30	45	65	Complex Patient/Complex A	1	20	36	50	93	mplex Patient/Complex Anesth	1	280	360	480

	1E. Post-anesthesia time					Post-Induction Anesthesia Time-Intensity Allocation (%)						BBM Value Calculation			
												1A: Pre-Anesthesia Evaluation	1B: Equipment and Supply Preparation		1C: Induction Period
															Pre-Induction Assessment
Max	Min	25th	Median	75th	Max	Level 1	Level 2	Level 3	Level 4	Level 5	Total	BBM value based on median	Minutes based on selected package	BBM value	Minutes
240	1	5	5.5	10.25	180	58.02%	24.69%	7.89%	5.38%	4.02%	100.00%	0.1792	7	0.0567	2
180	1	5	8	12	90	58.35%	24.03%	8.59%	4.66%	4.37%	100.00%	0.224	7	0.0567	2
240	1	3	5	11.5	60	67.83%	18.42%	5.68%	4.14%	3.92%	100.00%	0.224	7	0.0567	2
100	3	5	8	10	60	52.95%	24.68%	10.63%	5.59%	6.15%	100.00%	0.224	7	0.0567	2
90	2	5	8	10	60	55.50%	25.52%	9.68%	4.45%	4.84%	100.00%	0.224	7	0.0567	2
100	2	5	10	12	58	46.49%	28.12%	12.34%	6.66%	6.39%	100.00%	0.2464	7	0.0567	2
110	3	5	9.5	12	60	47.28%	28.28%	12.50%	6.65%	5.30%	100.00%	0.2352	7	0.0567	2

254	1	7	11	18	426	40.88%	30.58%	16.90%	7.01%	4.63%	100.00%	0.2688	7	0.0567	2
135	3	7	10	15	90	41.17%	32.94%	15.30%	6.04%	4.55%	100.00%	0.2912	7	0.0567	4
120	3	6	10	15	90	39.90%	33.35%	15.49%	6.22%	5.04%	100.00%	0.2912	7	0.0567	4
1205	1	6	10	18	435	44.48%	28.78%	15.28%	5.94%	5.52%	100.00%	0.224	7	0.0567	2
240	1	7.25	10	23.5	435	42.20%	30.57%	15.24%	6.67%	5.32%	100.00%	0.336	12	0.0972	2
250	1	8	10.5	19.5	427	40.20%	30.62%	15.96%	8.04%	5.18%	100.00%	0.336	12	0.0972	2
240	1	10	14.5	22.5	120	28.19%	22.36%	23.88%	17.19%	8.38%	100.00%	0.336	15	0.1215	4
296	1	8	12	21	476	38.28%	30.56%	18.33%	7.63%	5.19%	100.00%	0.336	12	0.0972	2
700	1	10	15	20.5	720	34.95%	28.07%	20.79%	9.93%	6.26%	100.00%	0.336	15	0.1215	4
420	1	14	20	32	120	21.37%	16.23%	19.09%	24.83%	18.49%	100.00%	0.448	25	0.2025	4
3158	0	15	20	30	480	17.80%	19.62%	20.65%	20.01%	21.92%	100.00%	0.56	25	0.2025	4
420	1	14.75	22	30	60	19.68%	15.15%	18.50%	22.00%	24.68%	100.00%	0.448	25	0.2025	4
660	1	20	28	45	120	19.48%	17.24%	23.24%	19.19%	20.86%	100.00%	0.5152	25	0.2025	4
												0			

				1D: Post-Induction Period	1E: Post-Anesthesia Time
	Induction				
BBM value	Minutes based on selected package	Intensity Factor	BBM value	BBM value based on median	BBM value based on median
0.0448	2	0.0636	0.1272	1.203609305	0.1232
0.0448	2	0.0636	0.1272	1.224873456	0.1792
0.0448	2	0.0636	0.1272	0.9728	0.1120
0.0448	2	0.0636	0.1272	0.5560	0.1792
0.0448	2	0.0636	0.1272	0.5428	0.1792
0.0448	2	0.0636	0.1272	0.5634	0.2240
0.0448	2	0.0636	0.1272	0.5524	0.2128

0.0448	2	0.0636	0.1272	4.028533275	0.2464
0.0896	8	0.1172	0.9376	0.716837447	0.224
0.0896	8	0.1172	0.9376	0.72444449	0.224
0.0448	5	0.0636	0.318	2.990201431	0.224
0.0448	5	0.0636	0.318	4.288830692	0.224
0.0448	5	0.0636	0.318	4.801415117	0.2352
0.0896	15	0.1172	1.758	6.2114	0.3248
0.0448	5	0.0636	0.318	5.485186391	0.2688
0.0896	8	0.1172	0.9376	8.585416	0.336
0.0896	15	0.1172	1.758	9.0187	0.4480
0.0896	15	0.1172	1.758	14.51846867	0.448
0.0896	15	0.1172	1.758	16.01516716	0.4928
0.0896	15	0.1172	1.758	21.52690286	0.6272

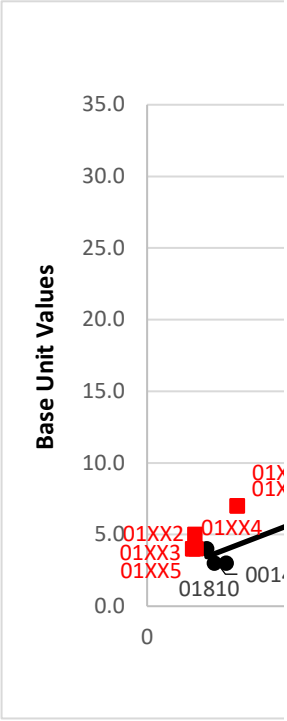
Build Block Methodology Calculations and Anesthesia Reference Service Comparison

ISSUE: Anesthesia Services for Image-Guided Spinal Procedures

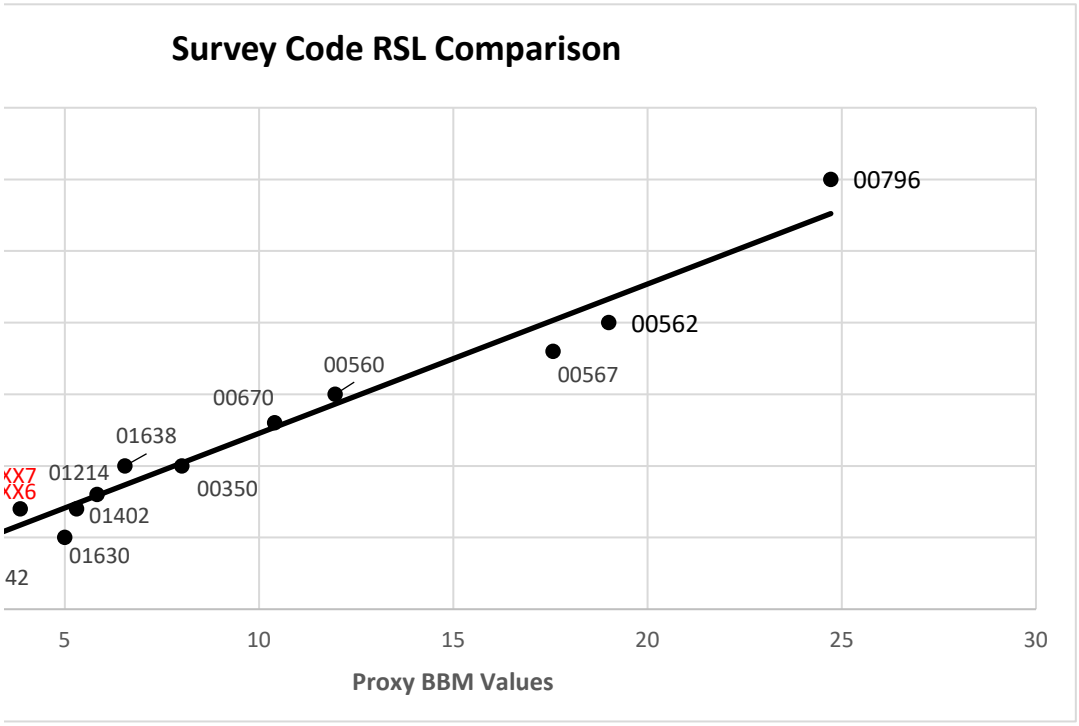
TAB: 4

	BB Value Estimates		Regression Comparison	
Code	X	Y	X	Y
00812	1.735	3	1.735	3.6608857
01810	2.038	3	2.038	3.9773211
00142	1.538	4	1.538	3.4553905
01630	5.004	5	5.004	7.0674518
00790	3.858	7	3.858	5.8732014
01402	5.309	7	5.309	7.385386
01214	5.833	8	5.833	7.9312083
00350	8.021	10	8.021	10.211531
01638	6.550	10	6.550	8.6787625
00670	10.406	13	10.406	12.697136
00560	11.965	15	11.965	14.321422
00567	17.577	18	17.577	20.169281
00562	19.006	20	19.006	21.658925
00796	24.719	30	24.719	27.612646

	Survey C
Code	BB Value
01XX2	1.187908
01XX3	1.174689
01XX4	1.22905
01XX5	1.26252
01XX6	2.315937
01XX7	2.323544



Code	Base Unit Value	
	4	*Survey 25th Percentile*
	4	*Survey 25th Percentile*
	5	*Survey 25th Percentile*
	4	*Survey 25th Percentile*
	7	*Survey Median*
	7	*Survey Median*



NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 01937-01942**
SPECIALTY SOCIETY(IES): American Society of Anesthesiologists (ASA)
PRESENTER(S): Gordon Morewood, MD, Richard Rosenquist MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
01937	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic	XXX
01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	XXX
01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	XXX
01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	XXX
01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	XXX
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
01937	A 67-year-old female has chronic neck pain radiating toward her right shoulder. An MRI demonstrated facet arthropathy at C4-C5 and multilevel degenerative disc disease. Diagnostic testing with cervical facet blocks under fluoroscopic guidance on the right at the C4-C5 level is indicated.
01938	A 71-year-old male presents with recurrent right leg pain, the ability to stand for only 10 minutes and walk less than one block, and minimal problems sitting. The patient's history includes a previous laminectomy at L4-L5; MRI with contrast material, showing a small recurrent herniation between L4-L5 with scar tissue; and neurodiagnostic studies compatible with L5 radiculopathy. He undergoes a transforaminal epidural injection of an anesthetic and/or anti-inflammatory agent at the L5-SI level.
01939	A 65-year-old female with constant neck pain caused by degenerative disc disease and cervical spondylosis received insufficient relief with conservative treatments. Previous trials of cervical medial branch nerve blocks proved beneficial (separately reported). Radiofrequency neurotomy is performed on two medial branch nerves innervating the unilateral symptomatic facet joint.
01940	A 65-year-old male with constant low back pain due to degenerative disc disease and facet arthropathy received insufficient relief with conservative treatments. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He undergoes radiofrequency neurotomy of the two medial branch nerves innervating the unilateral symptomatic facet joint.
01941	A 75-year-old female develops sudden, severe mid-back pain after lifting her grandchild. Plain radiographs reveal an acute compression fracture with severe anterior wedging involving T10 and consequent new kyphosis. Pain persists despite a period of conservative care. After referral, percutaneous thoracic vertebral augmentation (and bone biopsy, if indicated) is performed.
01942	A 75-year-old female presents with severe, persistent low back pain and progressive spinal deformity secondary to osteoporotic vertebral collapse. Plain radiographs reveal an acute

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	compression fracture of L3. Despite conservative medical management, pain persists. Percutaneous lumbar vertebral augmentation (and bone biopsy, if indicated) is performed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

We are requesting the standard anesthesia PE package. *CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiologists of 11 minutes and agreed that this was a direct practice expense; however, 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.*

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

01935 and 01936

3. Is this code(s) typically reported with an E/M service?
Is this code(s) typically reported with the E/M service in the nonfacility?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

No

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

N/A

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

3 minutes – anesthesia scheduling ***5 minutes – case assignment, scheduling coordination, and completion of forms***

   b. Service period (includes pre, intra and post):

   c. Post-service period:

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S): 01937-01942**

SPECIALTY SOCIETY(IES): American Society of Anesthesiologists (ASA)

PRESENTER(S): Gordon Morewood, MD, Richard Rosenquist MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
01937	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic	XXX
01938	Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral	XXX
01939	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic	XXX
01940	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral	XXX
01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic	XXX
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg. kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral	XXX

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
01937	A 67-year-old female has chronic neck pain radiating toward her right shoulder. An MRI demonstrated facet arthropathy at C4-C5 and multilevel degenerative disc disease. Diagnostic testing with cervical facet blocks under fluoroscopic guidance on the right at the C4-C5 level is indicated.
01938	A 71-year-old male presents with recurrent right leg pain, the ability to stand for only 10 minutes and walk less than one block, and minimal problems sitting. The patient's history includes a previous laminectomy at L4-L5; MRI with contrast material, showing a small recurrent herniation between L4-L5 with scar tissue; and neurodiagnostic studies compatible with L5 radiculopathy. He undergoes a transforaminal epidural injection of an anesthetic and/or anti-inflammatory agent at the L5-SI level.
01939	A 65-year-old female with constant neck pain caused by degenerative disc disease and cervical spondylosis received insufficient relief with conservative treatments. Previous trials of cervical medial branch nerve blocks proved beneficial (separately reported). Radiofrequency neurotomy is performed on two medial branch nerves innervating the unilateral symptomatic facet joint.
01940	A 65-year-old male with constant low back pain due to degenerative disc disease and facet arthropathy received insufficient relief with conservative treatments. Previous trials of lumbar medial branch nerve blocks proved beneficial (separately reported). He undergoes radiofrequency neurotomy of the two medial branch nerves innervating the unilateral symptomatic facet joint.
01941	A 75-year-old female develops sudden, severe mid-back pain after lifting her grandchild. Plain radiographs reveal an acute compression fracture with severe anterior wedging involving T10 and consequent new kyphosis. Pain persists despite a period of conservative care. After referral, percutaneous thoracic vertebral augmentation (and bone biopsy, if indicated) is performed.
01942	A 75-year-old female presents with severe, persistent low back pain and progressive spinal deformity secondary to osteoporotic vertebral collapse. Plain radiographs reveal an acute

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	compression fracture of L3. Despite conservative medical management, pain persists. Percutaneous lumbar vertebral augmentation (and bone biopsy, if indicated) is performed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

We are requesting the standard anesthesia PE package. *CMS requested the PERC discuss the appropriateness of direct practice expense of clinical labor employed by the physician as a cost in the facility setting. The PERC carefully discussed the recommendation by the American Society of Anesthesiologists of 11 minutes and agreed that this was a direct practice expense; however, 8 minutes of clinical labor time was more appropriate. The PERC recommends 8 minutes of clinical labor time for all anesthesia codes consisting of 3 minutes of anesthesia scheduling and 5 minutes of case assignment, scheduling coordination, and completion of forms.*

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

01935 and 01936

3. Is this code(s) typically reported with an E/M service?

N/A

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

3 minutes – anesthesia scheduling
5 minutes – case assignment, scheduling coordination, and completion of forms

   b. Service period (includes pre, intra and post):

   c. Post-service period:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**REFERENCE CODE**		**CURRENT**	
2						**01935**		**01936**		**01935**	
3		***RUC Collaboration Website***				Anesthesia for percutaneous image guided procedures on the spine and spinal cord;		Anesthesia for percutaneous image guided procedures on the spine and spinal cord;		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	
4	**Clinical Activity Code**	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37						
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37						
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37						
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37						
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37						
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37						
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37						
22	CA008	Perform regulatory mandated quality assurance activity (pre-Schedule (3 min), assign case and complete forms (3 min) for anesthesia	L037D	RN/LPN/MTA	0.37						
23	CA041		L037D	RN/LPN/MTA	0.37	8	8	8	8	8	8
24			L037D	RN/LPN/MTA	0.37						
25			L037D	RN/LPN/MTA	0.37						
26		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37						
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37						
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37						
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37						
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37						
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37						
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37						
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37						
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37						
42			L037D	RN/LPN/MTA	0.37						
45		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37						
48		**Intra-service (of service period)**									
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
51	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37						
55			L037D	RN/LPN/MTA	0.37						
56		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37						
59		**Post-Service (of service period)**									
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37						
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37						
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37						
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37						
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37						
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37						
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L037D	RN/LPN/MTA	0.37						
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37						
70	CA032	Scan exam documents into PACS. Complete exam in RIS system	L037D	RN/LPN/MTA	0.37						
71	CA033	Perform regulatory mandated quality assurance activity (service	L037D	RN/LPN/MTA	0.37						
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L037D	RN/LPN/MTA	0.37						
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37						
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**	
75			L037D	RN/LPN/MTA	0.37						
78		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37						
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37						
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37						
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27								
89		99213 36 minutes	36								
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37						
96		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37						
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**REFERENCE CODE**		**CURRENT**	
2						**01935**		**01936**		**01935**	
3		***RUC Collaboration Website***				Anesthesia for percutaneous image guided procedures on the spine and spinal cord;		Anesthesia for percutaneous image guided procedures on the spine and spinal cord;		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	
4	**Clinical Activity Code**	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102											
103											
104											
105											
106											
107											
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112											
113											
114											
115											
116											
117											
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	M	N	O	P	Q	R	S	T	U	V
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED		CURRENT		CURRENT		RECOMMENDED	
2			01936		1937		01935		01936		1938	
3		***RUC Collaboration Website***	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic		Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic		Anesthesia for percutaneous image guided injection, drainage or aspiration procedures on the	
4	Clinical Activity Code	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**										
5		**LOCATION**	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		**GLOBAL PERIOD**	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96
8		**TOTAL CLINICAL STAFF TIME**	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)										
17	CA003	Schedule space and equipment in facility										
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription										
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-Schedule (5 min), assign case and complete forms (5 min) for anesthesia										
23	CA041		8	8	8	8	8	8	8	8	8	8
24												
25												
26		*Other activity: please include short clinical description here and type now in column A*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available										
34	CA010	Obtain vital signs										
35	CA011	Provide education/obtain consent										
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies										
38	CA014	Confirm order, protocol exam										
39	CA015	Setup scope (nonfacility setting only)										
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient										
41	CA017	Sedate/apply anesthesia										
42												
45		*Other activity: please include short clinical description here and type now in column A*										
48		**Intra-service (of service period)**										
49	CA018	Assist physician or other qualified healthcare professional--directly										
50	CA019	Assist physician or other qualified healthcare professional--directly related physician work time (62%)										
51	CA020	Assist physician or other qualified healthcare professional--directly										
52	CA021	Perform procedure/service--NOT directly related to physician work time										
55												
56		*Other activity: please include short clinical description here and type now in column A*										
59		**Post-Service (of service period)**										
60	CA022	Monitor patient following procedure/service, multitasking 1:4										
61	CA023	Monitor patient following procedure/service, no multitasking										
62	CA024	Clean room/equipment by clinical staff										
63	CA025	Clean scope										
64	CA026	Clean surgical instrument package										
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
66	CA028	Review/read post-procedure x-ray, lab and pathology reports										
67	CA029	Check dressings, catheters, wounds										
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page										
69	CA031	Review examination with interpreting MD/DO										
70	CA032	Scan exam documents into PACS. Complete exam in RIS system										
71	CA033	Perform regulatory mandated quality assurance activity (service										
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)										
73	CA035	Review home care instructions, coordinate visits/prescriptions										
74	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a	
75												
78		*Other activity: please include short clinical description here and type now in column A*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037	Conduct patient communications										
85	CA038	Coordinate post-procedure services										
86		***Office visits: List Number and Level of Office Visits***	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
93												
96		*Other activity: please include short clinical description here and type now in column A*										
99		**End: with last office visit before end of global period**										

	A	B	M	N	O	P	Q	R	S	T	U	V
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**CURRENT**		**RECOMMENDED**	
2			**01936**		**1937**		**01935**		**01936**		**1938**	
3		***RUC Collaboration Website***	Anesthesia for		Anesthesia for		Anesthesia for		Anesthesia for		Anesthesia for	
4	**Clinical Activity Code**	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**	percutaneous image guided procedures on the spine and spinal cord; therapeutic		percutaneous image guided injection, drainage or aspiration procedures on the		percutaneous image guided procedures on the spine and spinal cord; diagnostic		percutaneous image guided procedures on the spine and spinal cord; therapeutic		percutaneous image guided injection, drainage or aspiration procedures on the	
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	**Equipment Code**	**EQUIPMENT**										
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	W	X	Y	Z	AA	AB	AC	AD	AE	AF
1	RUC Practice Expense Spreadsheet		CURRENT		CURRENT		RECOMMENDED		CURRENT		CURRENT	
2			01935		01936		1939		01935		01936	
3		***RUC Collaboration Website***	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic		Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic	
4	Clinical Activity Code	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**										
5		**LOCATION**	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		**GLOBAL PERIOD**	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96
8		**TOTAL CLINICAL STAFF TIME**	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96	$ 2.96
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)										
17	CA003	Schedule space and equipment in facility										
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription										
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-Schedule (3 min), assign case and complete forms (3 min) for anesthesia										
23	CA041		8	8	8	8	8	8	8	8	8	8
24												
25												
26		*Other activity: please include short clinical description here and type now in column A*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available										
34	CA010	Obtain vital signs										
35	CA011	Provide education/obtain consent										
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies										
38	CA014	Confirm order, protocol exam										
39	CA015	Setup scope (nonfacility setting only)										
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient										
41	CA017	Sedate/apply anesthesia										
42												
45		*Other activity: please include short clinical description here and type now in column A*										
48		**Intra-service (of service period)**										
49	CA018	Assist physician or other qualified healthcare professional---directly										
50	CA019	Assist physician or other qualified healthcare professional---directly										
51	CA020	Assist physician or other qualified healthcare professional---directly										
52	CA021	Perform procedure/service---NOT directly related to physician work time										
55												
56		*Other activity: please include short clinical description here and type now in column A*										
59		**Post-Service (of service period)**										
60	CA022	Monitor patient following procedure/service, multitasking 1:4										
61	CA023	Monitor patient following procedure/service, no multitasking										
62	CA024	Clean room/equipment by clinical staff										
63	CA025	Clean scope										
64	CA026	Clean surgical instrument package										
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
66	CA028	Review/read post-procedure x-ray, lab and pathology reports										
67	CA029	Check dressings, catheters, wounds										
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page										
69	CA031	Review examination with interpreting MD/DO										
70	CA032	Scan exam documents into PACS. Complete exam in RIS system										
71	CA033	Perform regulatory mandated quality assurance activity (service										
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)										
73	CA035	Review home care instructions, coordinate visits/prescriptions										
74	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a	
75												
78		*Other activity: please include short clinical description here and type now in column A*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037	Conduct patient communications										
85	CA038	Coordinate post-procedure services										
86		***Office visits: List Number and Level of Office Visits***	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
93												
96		*Other activity: please include short clinical description here and type now in column A*										
99		**End: with last office visit before end of global period**										

	A	B	W	X	Y	Z	AA	AB	AC	AD	AE	AF
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**CURRENT**	
2			**01935**		**01936**		**1939**		**01935**		**01936**	
3		***RUC Collaboration Website***	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic		Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic	
4	**Clinical Activity Code**	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	**Equipment Code**	**EQUIPMENT**										
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP
1	RUC Practice Expense Spreadsheet		RECOMMENDED		CURRENT		CURRENT		RECOMMENDED		CURRENT	
2			01940		01935		01936		01941		01935	
3		***RUC Collaboration Website***	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic		Anesthesia for percutaneous image guided neuromodulation or intravertebral		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	
4	Clinical Activity Code	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)										
17	CA003	Schedule space and equipment in facility										
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription										
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-Schedule (5 min), assign case and complete forms (5 min) for anesthesia										
23	CA041		8	8	8	8	8	8	8	8	8	8
24												
25												
26		*Other activity: please include short clinical description here and type new in column A*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available										
34	CA010	Obtain vital signs										
35	CA011	Provide education/obtain consent										
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies										
38	CA014	Confirm order, protocol exam										
39	CA015	Setup scope (nonfacility setting only)										
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient										
41	CA017	Sedate/apply anesthesia										
42												
45		*Other activity: please include short clinical description here and type new in column A*										
48		**Intra-service (of service period)**										
49	CA018	Assist physician or other qualified healthcare professional---directly										
50	CA019	Assist physician or other qualified healthcare professional---directly										
51	CA020	Assist physician or other qualified healthcare professional---directly										
52	CA021	Perform procedure/service---NOT directly related to physician work time										
55												
56		*Other activity: please include short clinical description here and type new in column A*										
59		**Post-Service (of service period)**										
60	CA022	Monitor patient following procedure/service, multitasking 1:4										
61	CA023	Monitor patient following procedure/service, no multitasking										
62	CA024	Clean room/equipment by clinical staff										
63	CA025	Clean scope										
64	CA026	Clean surgical instrument package										
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
66	CA028	Review/read post-procedure x-ray, lab and pathology reports										
67	CA029	Check dressings, catheters, wounds										
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page										
69	CA031	Review examination with interpreting MD/DO										
70	CA032	Scan exam documents into PACS. Complete exam in RIS system										
71	CA033	Perform regulatory mandated quality assurance activity (service										
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)										
73	CA035	Review home care instructions, coordinate visits/prescriptions										
74	CA036	Discharge day management	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75												
78		*Other activity: please include short clinical description here and type new in column A*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037	Conduct patient communications										
85	CA038	Coordinate post-procedure services										
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type new in column A*										
99		**End: with last office visit before end of global period**										

	A	B	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**01940**		**01935**		**01936**		**01941**		**01935**	
3		***RUC Collaboration Website***	Anesthesia for percutaneous image guided destruction procedures by neurolytic agent on		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic		Anesthesia for percutaneous image guided neuromodulation or intravertebral		Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic	
4	**Clinical Activity Code**	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	**Equipment Code**	**EQUIPMENT**										
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	AQ	AR	AS	AT
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**	
2			**01936**		**01942**	
3		***RUC Collaboration Website***	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic		Anesthesia for percutaneous image guided neuromodulation or intravertebral	
4	**Clinical Activity Code**	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**				
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
13		**PRE-SERVICE PERIOD**				
14		**Start: Following visit when decision for surgery/procedure made**				
15	CA001	Complete pre-service diagnostic and referral forms				
16	CA002	Coordinate pre-surgery services (including test results)				
17	CA003	Schedule space and equipment in facility				
18	CA004	Provide pre-service education/obtain consent				
19	CA005	Complete pre-procedure phone calls and prescription				
20	CA006	Confirm availability of prior images/studies				
21	CA007	Review patient clinical extant information and questionnaire				
22	CA008	Perform regulatory mandated quality assurance activity (pre-Schedule (5 min), assign case and complete forms (5 min) for anesthesia				
23	CA041		8	8	8	8
24						
25						
26		*Other activity: please include short clinical description here and type now in column A*				
29		**End: When patient enters office/facility for surgery/procedure**				
30		**SERVICE PERIOD**				
31		**Start: When patient enters office/facility for surgery/procedure:**				
32		**Pre-Service (of service period)**				
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available				
34	CA010	Obtain vital signs				
35	CA011	Provide education/obtain consent				
36	CA012	Review requisition, assess for special needs				
37	CA013	Prepare room, equipment and supplies				
38	CA014	Confirm order, protocol exam				
39	CA015	Setup scope (nonfacility setting only)				
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient				
41	CA017	Sedate/apply anesthesia				
42						
45		*Other activity: please include short clinical description here and type now in column A*				
48		**Intra-service (of service period)**				
49	CA018	Assist physician or other qualified healthcare professional---directly				
50	CA019	Assist physician or other qualified healthcare professional---directly				
51	CA020	Assist physician or other qualified healthcare professional---directly				
52	CA021	Perform procedure/service---NOT directly related to physician work time				
55						
56		*Other activity: please include short clinical description here and type now in column A*				
59		**Post-Service (of service period)**				
60	CA022	Monitor patient following procedure/service, multitasking 1:4				
61	CA023	Monitor patient following procedure/service, no multitasking				
62	CA024	Clean room/equipment by clinical staff				
63	CA025	Clean scope				
64	CA026	Clean surgical instrument package				
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions				
66	CA028	Review/read post-procedure x-ray, lab and pathology reports				
67	CA029	Check dressings, catheters, wounds				
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page				
69	CA031	Review examination with interpreting MD/DO				
70	CA032	Scan exam documents into PACS. Complete exam in RIS system				
71	CA033	Perform regulatory mandated quality assurance activity (service				
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)				
73	CA035	Review home care instructions, coordinate visits/prescriptions				
74	CA036	Discharge day management	**n/a**		**n/a**	
75						
78		*Other activity: please include short clinical description here and type now in column A*				
81		**End: Patient leaves office/facility**				
82		**POST-SERVICE PERIOD**				
83		**Start: Patient leaves office/facility**				
84	CA037	Conduct patient communications				
85	CA038	Coordinate post-procedure services				
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes				
88		99212 27 minutes				
89		99213 36 minutes				
90		99214 53 minutes				
91		99215 63 minutes				
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**
93						
96		*Other activity: please include short clinical description here and type now in column A*				
99		**End: with last office visit before end of global period**				

	A	B	AQ	AR	AS	AT
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**	
2			**01936**		**01942**	
3		***RUC Collaboration Website***	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic		Anesthesia for percutaneous image guided neuromodulation or intravertebral	
4	**Clinical Activity Code**	**Meeting Date:** **Revision Date (if applicable):** **Tab:** **Specialty:**				
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.96**	**$ 2.96**	**$ 2.96**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**8.0**	**8.0**	**8.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**				
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**
102						
103						
104						
105						
106						
107						
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*				
110	**Equipment Code**	**EQUIPMENT**				
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**
112						
113						
114						
115						
116						
117						
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*				

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Closed Treatment of Nasal Bone Fracture – Tab 5

In October 2020, the CPT Editorial Panel deleted code 21310 and revised two codes to add "with manipulation" to their CPT long descriptors and added a parenthetical to report the appropriate Evaluation and Management (E/M) code for closed treatment of nasal bone fracture without manipulation.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence to recommend an increase in value for CPT codes 21315 *Closed treatment of nasal bone fracture with manipulation; without stabilization* and 21320 *Closed treatment of nasal bone fracture with manipulation; with stabilization* based on evidence that flawed methodology was used in the previous valuation and there was a change in the dominant specialty performing these services. Specifically, based on the 1991 Federal Register, these codes were assigned work values based on "physician work value[s] established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors." This may explain why code 21315 currently has a negative IWPUT and demonstrates that a flawed methodology was used in the previous valuation as there is a discrepancy between this information and data provided by the AMA which indicates a Harvard phase 4 study was done for each code, resulting in 19 responses for code 21315 and 103 responses for code 21320. The RUC agreed that compelling evidence is met from a flawed methodology used in the previous valuation. Additionally, for codes 21315 and 21320, there has been a change in specialty from oral maxillofacial surgery to now otolaryngology and plastic surgery. **The RUC agreed that there is compelling evidence that there has been a change in the dominant specialty as well as evidence that flawed methodology was used in the previous valuation of these services.**

Change in Global Period
It is no longer typical to see the patient within 10 days post-procedure. There is little to be gained by examination prior to that given the degree of swelling which can often obscure the final result. For code 21320, the splint can either be removed after 10 days or removed by the patient at home, again not requiring a visit within 10 days post-procedure. The RUC agreed with the global period change from 010-day to 000-day global.

21315 *Closed treatment of nasal bone fracture with manipulation; without stabilization*
The RUC reviewed the survey results from 191 otolaryngologists and plastic surgeons and determined that the survey 25th percentile work RVU of 2.00 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 30 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 15 minutes of intra-service time, and 10 minutes of immediate post-service time.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC compared the survey code to the second top key reference code 31574 *Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral* (work RVU= 2.43, intra-service time of 15 minutes and total time of 55 minutes) and noted that both codes have identical intra-service time and should be valued similarly however, the survey code has 13 more minutes of total time. Many survey respondents (44%) that selected code 31574 rated the survey code more intense/complex than the second top key reference service, further warranting the recommended work value. Additionally, the RUC compared the survey code to code 15040 *Harvest of skin for tissue cultured skin autograft, 100 sq cm or less* (work RVU= 2.00, intra-service time of 15 minutes and total time of 60 minutes) and noted that both codes require the same intra-service time and similar total time justifying the recommended survey 25th percentile work value of 2.00. **The RUC recommends a work RVU of 2.00 for CPT code 21315.**

21320 *Closed treatment of nasal bone fracture with manipulation; with stabilization*
The RUC reviewed the survey results from 219 otolaryngologists and plastic surgeons and determined that the survey 25th percentile work RVU of 2.33 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 30 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 20 minutes of intra-service time, and 12 minutes of immediate post-service time.

The RUC compared the survey code to the top key reference code 43191 *Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)* (work RVU= 2.49, intra-service time of 20 minutes and total time of 86 minutes) and noted that both codes have identical intra-service time. Although the top key reference code has 11 more minutes of total time, most survey respondents (68%) that selected this top key reference code also rated the survey code more intense/complex than the top key reference service. Additionally, the RUC compared the survey code to code 43204 *Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices* (work RVU= 2.33 and intra-service time of 20 minutes) and agreed that both codes require the same intra-service time and amount of physician work. **The RUC recommends a work RVU of 2.33 for CPT code 21320.**

Practice Expense
The Practice Expense Subcommittee removed SG066 *packing, gauze w-petrolatum, 0.5in (6yd uou)* and CA014 *Confirm order, protocol exam* as it was determined that, while the code is done with imaging present, imaging is not being done at that time. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Musculoskeletal System** **Head** **Fracture and/or Dislocation**				
~~21310~~	-	~~Closed treatment of nasal bone fracture without manipulation~~ (21310 has been deleted. To report closed treatment of nasal bone fracture without manipulation or stabilization, use appropriate E/M code)	~~000~~	N/A
▲ 21315	I1	Closed treatment of nasal bone fracture with manipulation; without stabilization (To report closed treatment of nasal bone fracture without manipulation or stabilization, use appropriate E/M code)	~~010~~ 000	2.00
▲ 21320	I2	with stabilization	~~010~~ 000	2.33

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21315 Tracking Number Original Specialty Recommended RVU: **2.00**
Presented Recommended RVU: **2.00**
Global Period: 000 Current Work RVU: **1.83** RUC Recommended RVU: **2.00**

CPT Descriptor: Closed treatment of nasal bone fracture with manipulation; without stabilization

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male who sustained a closed, displaced nasal fracture undergoes closed reduction of the nasal fracture.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patients and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam. Radiologic examinations are reviewed. Reconcile medications and allergies. Address NPO status and timing. Discuss the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common complications. Discussion with the anesthesiologist regarding the anesthetic plan and the approximate length of the case. Review and obtain informed consent. Review pre-operative photographs of the external nose prior to the injury. The availability of all required instruments and supplies is verified. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The patient is positioned. Pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. The surgeon scrubs, gowns and preps the patient for the procedure.

Description of Intra-Service Work: The physician carefully places nasal instruments (ie Goldman elevator) into the nose and realigns the fractured nasal bones into correct anatomic position. Comparisons are made between the patients' pre-injury appearance and the reduced nasal fracture. This typically requires multiple manipulations to ensure adequate cosmesis and nasal airflow. The nasal cavity is repacked with cottonoids soaked in topical decongestant to ensure hemostasis. Once hemostasis is achieved, the cottonoids are removed.

Description of Post-Service Work: The patient is observed during emergence from anesthesia. The procedure is dictated. Discharge medications are reconciled. The prescription drug monitoring database is reviewed. Postoperative orders, medications and instructions are written. There is a discussion with the family and patient regarding the procedure and findings. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review of the written postoperative instructions. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021		
Presenter(s):	R. Peter Manes, MD Jeffrey Kozlow, MD		
Specialty Society(ies):	AAO-HNS, ASPS		
CPT Code:	21315		
Sample Size:	5437	**Resp N:**	191
Description of Sample:	AAO-HNS surveyed a random, targeted sample of 3839 otolaryngologists with the designation of general practice or facial plastics. ASPS surveyed a random sample of 1598 plastic surgeons.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**3.00**	6.00	75.00
Survey RVW:	0.50	2.00	**2.50**	3.00	20.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	3.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	21315	**Recommended Physician Work RVU: 2.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**30.00**	**-20.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43191	000	2.49	**RUC Time**

CPT Descriptor Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31574	000	2.43	**RUC Time**

CPT Descriptor Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64479	000	2.29	**RUC Time**	7,531,319

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36514	000	1.81	**RUC Time**	3,128,673

CPT Descriptor 2 Therapeutic apheresis; for plasma pheresis

Other Reference CPT Code	Global	Work RVU	Time Source
15040	000	2.00	**RUC Time**

CPT Descriptor Harvest of skin for tissue cultured skin autograft, 100 sq cm or less

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 43 **% of respondents:** 22.5 **%**

Number of respondents who choose 2nd Key Reference Code: 25 **% of respondents:** 13.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 21315	Top Key Reference CPT Code: 43191	2nd Key Reference CPT Code: **31574**
Median Pre-Service Time	43.00	51.00	30.00
Median Intra-Service Time	15.00	20.00	15.00
Median Immediate Post-service Time	10.00	15.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**68.00**	**86.00**	**55.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	25%	42%	26%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	12%	23%	65%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	35%	51%
Physical effort required	5%	47%	48%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	22%	76%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	12%	44%	40%	4%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	28%	40%	32%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	16%	64%	20%
Physical effort required	12%	44%	44%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	12%	32%	56%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:
In October 2020, the Academy brought forward a Code Change Application requesting revisions to the nasal fracture family of CPT codes (21315 and 21320). The Panel approved these changes and requested that the codes be surveyed following the CPT meeting, based on the fact that they had never been RUC surveyed. These changes will be published in the 2022 edition of the CPT Book.

Change in global for these codes:
In preparation for the RUC survey, our specialties reviewed the global for these codes and determined that there was great variability in the timing of the performance of the post-operative visit. Furthermore, it became clear that the post-operative visit rarely takes place within the first 10 days after surgery. In order to allow for a more accurate reflection of the actual post-operative work, we submitted the request to CMS to modify the prior global of 010, to a 000 global going forward.

Survey Sample and Process:
A survey request was sent to a targeted, random selection of members from the American Academy of Otolaryngology – Head and Neck Surgery who self-designated as one or more of the following sub-specialties: General Otolaryngology, or Facial Plastics. Additionally, the American Society of Plastic Surgeons surveyed a random sampling of 1598 members.

Key Reference Code: Respondents for both specialties selected the same key reference codes for 21315, reference code 43191 Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure) and 31574 Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral.

Recommendation (Work and Intra Time):
We are recommending a work RVU of **2.00 and 15 minutes of intra service time**, based on our survey's 25th percentile.

Compelling evidence: We recognize that our requested RVW of 2.00 is above existing value for this code and therefore, requires compelling evidence.

1. Based on the 1991 Federal Register, these codes were assigned RVUs based on "Source 2" information. This is defined as "Physician work value[s] established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors." This assignment of values based on "Source 2" information means the code was never ***surveyed by Harvard.*** This may explain why CPT 21315 currently has a negative IWPUT. We believe this speaks to compelling evidence and demonstrates a **flawed methodology was used in the previous valuation** as there is a discrepancy between this information and data provided by the AMA staff which indicates a Harvard phase 4 study was done for each code, resulting in 19 responses for 21315 and 103 for 21320. Given that it is unclear whether existing valuation is based on a Harvard survey or Source 2 data, we feel compelling evidence of "flawed methodology used in the previous valuation" is met.

2. Additionally, for both codes, there has been a **change in specialty** from Oral Maxillofacial Surgeons to Otolaryngology and Plastic Surgery. This is supported based on the database information that indicates these codes were valued using input from Oral Maxillofacial Surgeons, not Otolaryngologists or Plastic Surgeons.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3-FAC (Straightforward Patient/Difficult Procedure)
Evaluation Time – We are recommending 30 minutes of evaluation time which is a decrease of 3 minutes from the pre-service package time based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is a decrease of 2 minutes from the median survey time, but consistent with the pre-service package time for this activity.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is a decrease of 5 minutes from the selected pre-service package time, based on our survey median.

This results in a total recommended pre time of 43 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A (General Anesthesia or Complex Regional Block/ Straightforward Procedure)
Recommended time has been reduced to 10 minutes which is a decrease of 20 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 10 minutes, taking the lesser of surveyed time or the pre-service package time.***

Supporting Reference Codes for the Recommended Value

This list was developed using the following search parameters in the RUC database: 000 globals that have been RUC reviewed, with intra time of 15 minutes, and total time between 40 and 60 minutes. Codes were then removed that had not been RUC reviewed more recently than 2005.

CPT Code	Long Desc	Global	IWPUT	Work RVU	Pre Eval Time	Pre Positioning Time	Pre Scrub, Dress, Wait Time	Intra Time	Immediate Post Time	Total Time	Most Recent RUC Review
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	000	0.0829	1.83	13	1.0	6.0	15	10	45	2011-04
47537	Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	000	0.0731	1.84	18	3.0	6.0	15	10	52	2015-10
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	000	0.089	1.89	10	3.0	5.0	15	10	43	2015-10
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	000	0.0866	1.90	10	5.0	5.0	15	10	45	2015-10
11983	Removal with reinsertion, non-biodegradable drug delivery implant	000	0.0938	1.91	15	1.0	4.0	15	5	40	2018-10
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	000	0.0842	1.93	15	3.0	5.0	15	10	48	2016-10
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	000	0.09	1.95	10	5.0	5.0	15	10	45	2015-10
15040	Harvest of skin for tissue cultured skin autograft, 100 sq cm or less	000	0.0757	2.00	15	10.0	10.0	15	10	60	2005-04
92960	Cardioversion, elective, electrical conversion of arrhythmia; external	000	0.0918	2.00	10	1.0	5.0	15	15	46	2010-10
93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	000	0.1052	2.00	5	2.0	5.0	15	10	37	2016-10
31577	Laryngoscopy, flexible; with removal of foreign body(s)	000	0.1053	2.19	13	1.0	9.0	15	10	48	2015-10
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other	000	0.1066	2.20	10	5.0	5.0	15	10	45	2015-10

	solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)										
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level	000	0.1076	2.29	13	5.0	6.0	15	10	49	2009-10
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	000	0.1133	2.39	14	3.0	5.0	15	12	49	2013-01
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral	000	0.1153	2.43	17	1.0	9.0	15	10	52	2015-10
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	000	0.1108	2.43	20	1.0	9.0	15	10	55	2015-10
31578	Laryngoscopy, flexible; with removal of lesion(s), non-laser	000	0.1168	2.43	16	1.0	9.0	15	10	51	2015-10
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	000	0.1416	2.50	5	5.0	5.0	15	5	35	2016-01

Intensity of Work

Review of IWPUT demonstrated that 21315 is similar to both our KRS Codes and MPC codes with a wRVU at the 25th percentile. In fact, respondents indicated this procedure is the same or more intense and complex than both KRS codes, however, the recommendation of the WRVU at the 25th percentile results in a lower IWPUT than both of the selected KRS services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21315

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Sometimes

Specialty Plastic Surgery How often? Sometimes

Specialty Emergency Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1572
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the 2019 Medicare RUC database utilization.

Specialty Otolaryngology Frequency 880 Percentage 55.97 %

Specialty Plastic Surgery Frequency 251 Percentage 15.96 %

Specialty Emergency Medicine Frequency 251 Percentage 15.96 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 572
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the 2019 volume for the service per the RUC database.

Specialty Otolaryngology Frequency 320 Percentage 55.94 %

Specialty Plastic Surgery Frequency 92 Percentage 16.08 %

Specialty Emergency Medicine Frequency 92 Percentage 16.08 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 21315

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21320 Tracking Number Original Specialty Recommended RVU: **2.33**
Presented Recommended RVU: **2.33**
Global Period: 000 Current Work RVU: **1.88** RUC Recommended RVU: **2.33**

CPT Descriptor: Closed treatment of nasal bone fracture with manipulation; with stabilization

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 20-year-old male who sustained a closed, displaced nasal fracture undergoes closed reduction of the nasal fracture.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patients and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam. Radiologic examinations are reviewed. Reconcile medications and allergies. Address NPO status and timing. Discuss the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common complications. Discussion with the anesthesiologist regarding the anesthetic plan and the approximate length of the case. Review and obtain informed consent. Review pre-operative photographs of the external nose prior to the injury. The availability of all required instruments and supplies is verified. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The patient is positioned. Pledgets soaked with topical decongestant are placed and adequate time is given to allow for decongestant to take place. Pledgets are then removed and injection with local anesthesia with vasoconstrictors is performed. Pledgets soaked with topical decongestant are then placed again. The surgeon scrubs, gowns and preps the patient for the procedure.

Description of Intra-Service Work: The physician carefully places nasal instruments (ie Goldman elevator) into the nose and realigns the fractured nasal bones into correct anatomic position. Comparisons are made between the patients' pre-injury appearance and the reduced nasal fracture. This typically requires multiple manipulations to ensure adequate cosmesis and nasal airflow. The nasal cavity is repacked with cottonoids soaked in topical decongestant to ensure hemostasis. Once hemostasis is achieved, the cottonoids are removed. The nasal cavity is then packed with gauze in order to provide internal support. The nasal skin is cleaned with an alcohol wipe. Adhesive is applied to the patients' skin and steri-strips are placed to protect the skin. An external splint is shaped to conform to the patients' external nose and placed. This is then further secured to the patients' skin with tape.

Description of Post-Service Work: The patient is observed during emergence from anesthesia. The procedure is dictated. Discharge medications are reconciled. The prescription drug monitoring database is reviewed. Postoperative orders, medications and instructions are written. There is a discussion with the family and patient regarding the procedure and findings. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review of the written postoperative instructions. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD Jeffrey Kozlow, MD					
Specialty Society(ies):	AAO-HNS, ASPS					
CPT Code:	21320					
Sample Size:	5437	**Resp N:**	219			
Description of Sample:	AAO-HNS surveyed a random, targeted sample of 3839 otolaryngologists with the designation of general practice or facial plastics. ASPS surveyed a random sample of 1598 plastic surgeons.					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	4.00	**6.00**	12.00	75.00	
Survey RVW:	0.50	2.33	**2.80**	3.30	20.00	
Pre-Service Evaluation Time:			**30.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	3.00	15.00	**20.00**	28.00	75.00	
Immediate Post Service-Time:	**12.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	21320	**Recommended Physician Work RVU: 2.33**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**12.00**	**30.00**	**-18.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43191	000	2.49	**RUC Time**

CPT Descriptor Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31574	000	2.43	**RUC Time**

CPT Descriptor Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64479	000	2.29	**RUC Time**	7,531,319

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36514	000	1.81	**RUC Time**	3,128,673

CPT Descriptor 2 Therapeutic apheresis; for plasma pheresis

Other Reference CPT Code	Global	Work RVU	Time Source
43204	000	2.33	**RUC Time**

CPT Descriptor Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 87 **% of respondents:** 39.7 **%**

Number of respondents who choose 2nd Key Reference Code: 20 **% of respondents:** 9.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 21320	Top Key Reference CPT Code: 43191	2nd Key Reference CPT Code: **31574**
Median Pre-Service Time	43.00	51.00	30.00
Median Intra-Service Time	20.00	20.00	15.00
Median Immediate Post-service Time	12.00	15.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**75.00**	**86.00**	**55.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	28%	44%	24%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	37%	55%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	12%	37%	51%
Physical effort required	6%	41%	53%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	22%	73%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	55%	25%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	60%	35%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	55%	25%
Physical effort required	5%	50%	45%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	35%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:
In October 2020, the Academy brought forward a Code Change Application requesting revisions to the nasal fracture family of CPT codes (21315 and 21320). The Panel approved these changes and requested that the codes be surveyed following the CPT meeting, based on the fact that they had never been RUC surveyed. These changes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:
A survey request was sent to a targeted, random selection of members from the American Academy of Otolaryngology – Head and Neck Surgery who self-designated as one or more of the following sub-specialties: General Otolaryngology, or Facial Plastics. Additionally, the American Society of Plastic Surgeons surveyed a random sampling of 1598 members.

Change in global for these codes:
In preparation for the RUC survey, our specialties reviewed the global for these codes and determined that there was great variability in the timing of the performance of the post-operative visit. Furthermore, it became clear that the post-operative visit rarely takes place within the first 10 days after surgery. In order to allow for a more accurate reflection of the actual post-operative work, we submitted the request to CMS to modify the prior global of 010, to a 000 global going forward.

Key Reference Code: Respondents for both specialties selected the same key reference codes for 21320, reference code 43191 Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure) and 31574 Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral.

Recommendation (Work and Intra Time):
We are recommending a work RVU of **2.33 and 20 minutes of intra service time**, based on our survey's 25th percentile.

Compelling evidence: We recognize that our requested RVW of 2.33 is above existing value for this code and therefore, requires compelling evidence.

1. Based on the 1991 Federal Register, these codes were assigned RVUs based on "Source 2" information. This is defined as "Physician work value[s] established by HCFA. It may have been a refinement of a Harvard value, or a gap fill for a code for which Harvard did not provide a value. These include codes reviewed by carrier medical directors." This assignment of values based on "Source 2" information means the code was never ***surveyed by Harvard.*** This may explain why CPT 21315 currently has a negative IWPUT. We believe this speaks to compelling evidence and demonstrates a **flawed methodology was used in the previous valuation** as there is a discrepancy between this information and data provided by the AMA staff which indicates a Harvard phase 4 study was done for each code, resulting in 19 responses for 21315 and 103 for 21320. Given that it is unclear whether existing valuation is based on a Harvard survey or Source 2 data, we feel compelling evidence of "flawed methodology used in the previous valuation" is met.
2. Additionally, for both codes, there has been a **change in specialty** from Oral Maxillofacial Surgeons to Otolaryngology and Plastic Surgery. This is supported based on the database information that indicates these codes were valued using input from Oral Maxillofacial Surgeons, not Otolaryngologists or Plastic Surgeons.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3-FAC (Straightforward Patient/Difficult Procedure)
Evaluation Time – We are recommending 30 minutes of evaluation time which is a decrease of 3 minutes from the pre-service package time based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is a decrease of 2 minutes from the median survey time, but consistent with the pre-service package time for this activity.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is a decrease of 5 minutes from the selected pre-service package time, based on our survey median.

This results in a total recommended pre time of 43 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A (General Anesthesia or Complex Regional Block/ Straightforward Procedure)
Recommended time has been reduced to 12 minutes which is a decrease of 18 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 12 minutes, taking the lesser of surveyed time or the pre-service package time.***

Supporting Reference Codes for the Recommended Value

This list was developed using the following search parameters in the RUC database: 000 globals that have been RUC reviewed, with intra time of 20 minutes, and total time between 70 and 80 minutes. All codes that have not been RUC reviewed prior to 2000 were removed.

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
36512	Therapeutic apheresis; for red blood cells	000	0.0384	2.00	20	75	2017-01	PATHOLOGY	2896
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	000	0.0783	2.61	20	73	2017-01	OTOLARYNGOLOGY	6458
30140	Submucous resection inferior turbinate, partial or complete, any method	000	0.0922	3.00	20	78	2016-10	OTOLARYNGOLOGY	49954
32551	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)	000	0.0998	3.04	20	73	2012-04	GENERAL SURGERY	33044
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	000	0.0951	3.04	20	74	2014-04	CARDIAC ELECTROPHYSIOLOGY	56
16035	Escharotomy; initial incision	000	0.131	3.74	20	70	2000-04	GENERAL PRACTICE	381

Intensity of Work

Review of IWPUT demonstrated that 21320 is similar to both our KRS Codes and MPC codes with a wRVU at the 25th percentile. In fact, respondents indicated this procedure is the same or more intense and complex than both KRS codes, however, the recommendation of the WRVU at the 25th percentile results in a lower IWPUT than both of the selected KRS services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21320

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Commonly

Specialty Plastic Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5910
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the 2019 Medicare RUC database utilization.

Specialty Otolaryngology Frequency 4373 Percentage 73.99 %

Specialty Plastic Surgery Frequency 1063 Percentage 17.98 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,970
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the 2019 volume for the service per the RUC database.

Specialty Otolaryngology Frequency 1458 Percentage 74.01 %

Specialty Plastic Surgery Frequency 355 Percentage 18.02 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 21320

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Closed Treatment of Nasal Bone Fracture

TAB: 5

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	43191	000	Esophagoscopy, rigid, transoral; diagnostic, including collection of	43	0.058	0.029			2.49			86	35	6	10			20			15																
2nd REF	31574	000	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous,	25	0.111	0.044			2.43			55	20	1	9			15			10																
CURRENT	21315	010	Closed treatment of nasal bone fracture; without stabilization		-0.006	0.018			1.83			99	25					30			21								1								
SVY	21315	000	Closed treatment of nasal bone fracture with manipulation; without stabilization	191	0.094	0.036	0.50	2.00	2.50	3.00	20.00	70	30	5	10	3	10	15	20	60	10												0	1	3	6	75
AAOHNS				139	0.102	0.038	1.01	2.00	2.50	3.00	7.00	65	25	5	10	4	10	15	20	60	10												0	1	3	7	60
ASPS				52	0.056	0.028	0.50	2.00	2.52	3.48	20.00	91.5	40	8	10	3	10	19	25	60	15												0	1	3	6	75
REC	21315	000	Closed treatment of nasal bone fracture with manipulation; without stabilization		0.064	0.029			2.00			68	30	3	10			15			10																
1st REF	43191	000	Esophagoscopy, rigid, transoral; diagnostic, including collection of	87	0.058	0.029			2.49			86	35	6	10			20			15																
2nd REF	31574	000	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous,	20	0.111	0.044			2.43			55	20	1	9			15			10																
CURRENT	21320	010	Closed treatment of nasal bone fracture; with stabilization		0.025	0.024			1.88			78	22					25			23								0.5								
SVY	21320	000	Closed treatment of nasal bone fracture with manipulation; with stabilization	219	0.083	0.036	0.50	2.33	2.80	3.30	20.00	77	30	5	10	3	15	20	28	75	12												0	4	6	12	75
AAOHNS				161	0.092	0.041	1.10	2.30	2.80	3.22	9.00	69	25	5	9	3	15	20	25	60	10												0	3	6	12	50
ASPS				58	0.056	0.030	0.50	2.50	3.00	4.70	20.00	102	43	8	10	3	16	26	31	75	15												0	4	8	12	75
REC	21320	000	Closed treatment of nasal bone fracture with manipulation; with stabilization		0.062	0.031			2.33			75	30	3	10			20			12																

Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY				NON-FAC	
		1	2	3	4	5**	6
	Total Pre-Service Time	**20**	**25**	**51**	**63**	**8**	**23**
	CATEGORY SUBTOTALS						
A	Pre-Service Evaluation (IWPUT =0.0224)	13	18	33	40	7	17
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	3	3	0	1
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	6	15	20	1	5
	DETAILS						
A	History and Exam (Performance and review of appropriate Pre-Tests)	5	10	10	15	4	9
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	4	1	1
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	5	5	2	3
A	Communicate with other professionals	0	0	5	5	0	2
A	Check/set-up room, supplies and equipment	1	1	5	5	0	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	5	5	0	1
A	Prepare/ review/ confirm procedure	1	1	1	1	0	0
B	Perform/ supervise patient positioning	1	1	3	3	0	1
C	Administer local/topical anesthesia	1	1	0	0	1	5
C	Observe (wait anesthesia care)	0	0	10	15	0	0
C	Dress and scrub for procedure	5	5	5	5	0	0

**If the procedure does not require local anesthesia, 1 minute should be removed from pre-service time

1 Straightforward Patient/Straightforward Procedure (No anesthesia care)
2 Difficult Patient/Straightforward Procedure (No anesthesia care)
3 Straightforward Patient/Difficult Procedure
4 Difficult Patient/Difficult Procedure
5 Procedure with minimal anesthesia care (If no anesthesia care deduct 1 minute)
6 Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect

Additional Positioning Times for Spinal Surgical Procedures

SS1	Anterior Neck Surgery (Supine) (eg ACDF)	15 Minutes
SS2	Posterior Neck Surgery (Prone) (eg laminectomy)	25 Minutes
SS3	Posterior Thoracic/Lumbar (Prone) (eg laminectomy)	15 Minutes

Additional Positior

SI1	Anterior Neck
SI2	Posterior Neck
SI3	Posterior Thor

SS4	Lateral Thoracic/Lumbar (Lateral) (eg corpectomy)	25 Minutes	**SI4** Lateral Thorac
SS5	Anterior Lumbar (Supine) (eg ALIF)	15 Minutes	

Additional Positioning Times for Urological Procedures

U1	Dorsal Lithotomy	5 Minutes

Notes:

- Roll-over cells for additional detail where available
- Straightforward procedure: Integumentary, Non-incisional endoscopy, natural orifice

ıing Times for Spinal Injection Procedures

	7 Minutes
	5 Minutes
	5 Minutes

7 Minutes

Detailed Description of Facility Based Post-Service Time Packages (Minu				
	7A Local Anesthesia/ Straightforward Procedure	**7B Local Anesthesia/ Complex Procedure**	**8A IV Sedation/ Straightforward Procedure**	**8B IV Sedation/ Complex Procedure**
Total Post-Service Time	**18**	**21**	**25**	**28**
Details:				
Application of Dressing[1]	2	2	2	2
Transfer of supine patient off table	1	1	1	1
Operative Note	5	5	5	5
Monitor patient recovery/stabilization	1	1	5	5
Communication with patient and/or family	5	5	5	5
Written post-operative note	2	5	2	5
Post-Operative Orders and Order Entry	2	2	5	5

Advisors may request additional time for circumstances that require additional work beyond the type of work described

1 This represents a simple dressing

tes)	
9A General Anesthesia or Complex Regional Block/ Straightforward Procedure	**9B General Anesthesia or Complex Regional Block/Complex Procedure**
30	**33**
2	2
1	1
5	5
10	10
5	5
2	5
5	5

SS Rec Summary

SAMPLE COMPLETED WORKSHEET

ISSUE: [TAB NAME]

TAB: 84

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW					Total Time	PRE			INTRA					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
							MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
1st REF	11111	000	xyz	30	0.029	0.032			4.25			131	5	5	5			30			5					1	1.0				1								
2nd REF	22222	000	def	15	0.055	0.038			5.15			137	10	5	5			35			5						1.0				1	1						
CURRENT	55555	000	abc		0.053	0.038			5.00			133	17					27			8					1	1.0				1							
SVY	55555	000	abc	78	0.045	0.034	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10					1	1.0				1			1	25	50	75	100
REC	55555	000	abc		0.020	0.030			4.25			142	17	1	3			30			10					1	1.0				1							

FACILITY DIRECT PE INPUTS

CPT CODE(S): 21315 21320
SPECIALTY SOCIETY(IES): AAO-HNS, ASPS
PRESENTER(S): R. Peter Manes, MD (AAO-HNS) & Jeffrey Kozlow, MD (ASPS)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
21315	Closed treatment of nasal bone fracture with manipulation; without stabilization	000

CPT Code	Long Descriptor	Global Period
21320	Closed treatment of nasal bone fracture with manipulation; with stabilization	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
21315	A 20-year-old male who sustained a closed, displaced nasal fracture undergoes closed reduction of the nasal fracture.

CPT Code	Vignette
21320	A 23-year-old male who sustained a closed displaced nasal fracture undergoes closed reduction of the nasal fracture with stabilization.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of general otolaryngology, facial plastics, and plastic surgery. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   21315 and 21320

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   We are recommending the standard for "minimal use of staff" for 000 globals for both codes in this family, when performed in the facility setting. This is not above the prior inputs for clinical staff

time, however, it is reflective of necessary staff activities to schedule space, provide education and consent to the patient, complete referral forms, and coordinate referral paperwork. The overall time for clinical staff activities for these codes has been dramatically reduced from prior inputs.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are not recommending an increase in cost for clinical staff time for either code.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Previously, all clinical activities were rolled into three inputs: Pre: CA008, Intra CA021, Post: CA038. Within our recommendations we have properly itemized the clinical staff activities in accordance with PE subcommittee standards and guidelines.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Typical staff activities when performed in the facility are: schedule space, provide education and consent to the patient, complete referral forms, and coordinate referral paperwork.

   b. Service period (includes pre, intra and post):

None when performed in the facility – changed to a 000 global

   c. Post-service period:

None when performed in the facility – changed to a 000 global

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

    N/A when done in the facility – 000 global

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

    N/A when done in the facility – 000 global

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

    N/A when done in the facility – 000 global

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

    N/A when done in the facility – 000 global

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

    N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

    N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS

CPT CODE(S): 21315 21320
SPECIALTY SOCIETY(IES): AAO-HNS, ASPS
PRESENTER(S): R. Peter Manes, MD (AAO-HNS) & Jeffrey Kozlow, MD (ASPS)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

These codes were previously 010 globals, therefore, they historically had time in the post-operative period for a follow up visit when performed in the facility. We have converted them to 000 globals, therefore, any clinical staff time, supplies or equipment that would have been used in the post-operative visits has been removed. Additionally, as mentioned above, previous PE inputs were all rolled into a single line item within the pre/intra/post period. We have broken those individual activities out, and assigned them the PE Subcommittee approved standard times for each applicable clinical staff activity in the pre-service.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
21315	Closed treatment of nasal bone fracture with manipulation; without stabilization	000

CPT Code	Long Descriptor	Global Period
21320	Closed treatment of nasal bone fracture with manipulation; with stabilization	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
21315	A 20-year-old male who sustained a closed, displaced nasal fracture undergoes closed reduction of the nasal fracture.

CPT Code	Vignette
21320	A 23-year-old male who sustained a closed displaced nasal fracture undergoes closed reduction of the nasal fracture with stabilization.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of general otolaryngology, facial plastics, and plastic surgery. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   21315 and 21320

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Is the dominant provider in the nonfacility different than for the global?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Otolaryngology 76%,
No, that is the dominant specialty overall.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

We are not requesting any time above PE subcommittee standards for any clinical activities.

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

We are not requesting any increased cost for clinical staff time over prior inputs, however, we are asking for increased pre time based on our request for the standard PE subcommittee times for "extensive use of clinical staff" for these 000 global procedures. Additionally, for 21320 only, our intra clinical staff time is increased by one minute over prior times, as a result of our intraservice survey time for the procedure of 20 minutes.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

We are requesting 5 minutes for this activity, based on the staff taking the following vitals: Temperature, heart rate, blood pressure, oxygen saturation, and respiration rate.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Staff complete pre-service referral forms, coordinate pre-procedure services, provide education and consent, and make follow up phone calls and prescriptions.

   b. Service period (includes pre, intra and post):

During the intra period the staff:
Greet the patient, gown them, ensure medical records are available, obtain five vitals listed above, prepare the room and equipment, and conduct a protocol exam, support the physician in the application of sedation/anesthesia, assist the physician throughout the entire procedure, monitor the patient for approximately 15 minutes post procedure, clean the room and equipment, clean the instruments used during the procedure, and check dressings. While checking the dressing they check the gauze dressing underneath the wound, confirm there is no epistaxis. For 21320, they also ensure the splint stays on and there is no bleeding. They then review home care instructions, including: encouraging them to safeguard their nose, try to limit blowing their nose, keep their head elevated, ice regularly, and use Afrin if they experience bleeding.

   c. Post-service period:

After the procedure the staff makes a phone call to the patient to confirm they are doing well and to answer any questions they may have.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

pack, minimum multi-specialty visit	**SA048**	**pack**	**4.0507**
paper, exam table		foot	7
gloves, non-sterile		pair	2
gown, patient		item	1
pillow case		item	1
cover, thermometer probe		item	1

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

pack, basic injection	**SA041**	**pack**		**11.365**
applicator, sponge-tipped		item	3	
bandage, strip 0.75in x 3in		item	1	
cap, surgical		item	1	
drape, sterile barrier 16in x 29in		item	1	
drape, sterile, for Mayo stand		item	1	
gauze, sterile 4in x 4in		item	2	
gown, surgical, sterile		item	1	
needle, 18-27g		item	2	
povidone soln (Betadine)		ml	10	
syringe 3ml		item	1	
underpad 2ftx3ft (Chux)		item	1	
pack, cleaning, surgical instruments	**SA043**	**pack**	1	**10.7922**
gloves, non-sterile		pair	2	
gown, staff, impervious		item	1	
face shield, splash protection		item	1	
autoclave bag		item	1	
autoclave tape		yd	0.33	
enzymatic detergent		oz	1	
cleaning brush, instruments		item	1	

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EQ234 ENT SMR cabinet – Default formula chosen
EQ170 Fiberoptic head light – Default formula chosen
EF008 exam chair – Default formula chosen
EQ137 basic instrument pack – Instrument pack formula chosen

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

These codes were previously 010 globals, therefore, they historically had time in the post-operative period for a follow up visit when performed in the facility. We have converted them to 000 globals, therefore, any clinical staff time, supplies or equipment that would have been used in the post-operative visits has been removed. Additionally, as mentioned above, previous PE inputs were all rolled into a single line item within the pre/intra/post period. We have broken those individual activities out, and assigned them the PE Subcommittee approved standard times for each applicable clinical staff activity in the pre-service. Other changes include: Replacing several individual supply line items with packs that comprised the majority of those materials. Specifically, removing lines 103, 104, 106-108, and 116; and replacing them with an injection pack (line 125) and a pack for cleaning surgical instruments (line 126).

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

We removed bacitracin from 21320 and reduced the tape to 6 inches from 12, and gauze to 1 for each code since it is a pack of 10. We also removed line 115 gauze with petroleum jelly for code 21320.

We also added in six new supplies: 4% lidocaine which is needed to numb the nose and surrounding area, two packs (described above), Atomizer tips and shield, Mastisol, and Steri Strips. The atomizer tip and shield are used to spray the nasal cavity with topical decongestant and anesthesia. Steri Strips are used on the skin to protect the skin under the splint. Mastisol is used to help secure the sterile strips to the skin.

We also added in one new piece of equipment: The basic instrument pack. The instruments in this pack are nasal speculum, bayonet forceps, and a Goldman elevator. The Goldman elevator is used to realign the fractured nasal bones into correct anatomic positions. The nasal speculum is used to open the nares for visualization and placement if instruments. The bayonet forceps are used to hold and place pledgets used for topical decongestant and anesthesia.

	A	B	D	E	F	I	J	K	L	O	P
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**21315**		**21315**		**21320**	
3		***RUC Collaboration Website***				Closed treatment of nasal bone fracture; without stabilization		Closed treatment of nasal bone fracture with manipulation; without stabilization		Closed treatment of nasal bone fracture; with stabilization	
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 5 Specialty: AAO-HNS, ASPS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**010**	**010**	**000**	**000**	**010**	**010**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$144.42**	**$ 43.18**	**$ 73.86**	**$ 5.55**	**$122.26**	**$ 23.17**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**106.0**	**67.0**	**68.0**	**15.0**	**78.5**	**38.5**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**13.0**	**19.0**	**18.0**	**15.0**	**13.0**	**19.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**57.0**	**12.0**	**47.0**	**0.0**	**52.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**36.0**	**36.0**	**3.0**	**0.0**	**14**	**14**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 39.22**	**$ 24.79**	**$ 25.16**	**$ 5.55**	**$ 29.05**	**$ 14.25**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	5	5	5	3	5	5
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37	3	3	3	3	3	3
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		3	0	3		3
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	5	5	7	3	5	5
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		3	3	3		3
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37						
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37						
23			L037D	RN/LPN/MTA	0.37						
26		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37						
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37	3		3		3	
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5		5		5	
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37						
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37						
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	2		2		2	
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37			0			
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	2				2	
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37	2		2		2	
42			L037D	RN/LPN/MTA	0.37						
45		*2004 PE listed "review charts 2 minutes"*	L037D	RN/LPN/MTA	0.37	2				2	
48		**Intra-service (of service period)**									
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37	30		15		25	
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
51	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37		6				
55			L037D	RN/LPN/MTA	0.37						
56		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37						
59		**Post-Service (of service period)**									
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37	5		4		5	
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37						
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3		3		3	
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37						
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37			10			
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37						
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	3		1		3	
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37						
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37						
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37						
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37						
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs,	L037D	RN/LPN/MTA	0.37						
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37			2			
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**	
75			L037D	RN/LPN/MTA	0.37		**6**				**6**
78		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37						
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37			3			
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37						
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27							0.5	0.5
89		99213 36 minutes	36			1	1				
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**36.0**	**36.0**	**0.0**	**0.0**	**13.5**	**13.5**
93			L037D	RN/LPN/MTA	0.37						
96		*Other activity: please include short clinical description here and type new*	L037D	RN/LPN/MTA	0.37						
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	I	J	K	L	O	P
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**21315**		**21315**		**21320**	
3		***RUC Collaboration Website***				Closed treatment of nasal bone fracture; without stabilization		Closed treatment of nasal bone fracture with manipulation; without stabilization		Closed treatment of nasal bone fracture; with stabilization	
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 5 Specialty: AAO-HNS, ASPS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**010**	**010**	**000**	**000**	**010**	**010**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$144.42**	**$ 43.18**	**$ 73.86**	**$ 5.55**	**$122.26**	**$ 23.17**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**106.0**	**67.0**	**68.0**	**15.0**	**78.5**	**38.5**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**13.0**	**19.0**	**18.0**	**15.0**	**13.0**	**19.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**57.0**	**12.0**	**47.0**	**0.0**	**52.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**36.0**	**36.0**	**3.0**	**0.0**	**14**	**14**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 101.76**	**$ 17.05**	**$ 46.75**	**$ -**	**$ 90.77**	**$ 8.40**
102	SA048	pack, minimum multi-specialty visit	4.0507	pack		2	1	1		1.5	0.5
103	SB022	gloves, non-sterile	0.246	pair		2	1			1.5	0.0
104	SB027	gown, staff, impervious	1.186	item		3	1			2.5	0.5
105	SB034	mask, surgical, with face shield	3.4	item		3	1	1		2.5	0.5
106	SB044	underpad 2ft x 3ft (Chux)	0.2975	item		2	1			2.5	0.5
107	SB046	drape, sterile, split-sheet	5.9506	item		1	-			1.0	0.0
108	SC051	syringe 10-12ml	0.2035	item		1	-			1.0	0.0
109	SC080	needle, OSHA compliant (SafetyGlide)	0.6985	item		2	-	1		2.0	0.0
110	SD009	canister, suction	4.2095	item		2	1	1		1.5	0.5
111	SD132	tubing, suction, non-latex (6ft uou)	0.9212	item		2	1	1		1.5	0.5
112	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)	2.7428	item		2	1	1		1.5	0.5
113	SG031	cottonoid	0.7933	item		2	-	4		2.0	0.0
114	SG056	gauze, sterile 4in x 4in (10 pack uou)	1.0995	item		6	-	1		1.0	0.0
115	SG066	**packing, gauze w-petrolatum, 0.5in (6yd uou)**	2.1193	item						1.0	0.0
116	SG073	splint, adhesive nasal (Denver)	23.0525	item		1	-			1.0	0.0
117	SG088	**tape, foam, elastic, 2in (Microfoam)**	0.0082	inch		12	-	6			
118	SH025	cocaine 4% solution, topical	5.2283	ml		4	-			4.0	0.0
119	SH049	lidocaine 2% w-epi inj (Xylocaine w-epi)	0.1253	ml		10	-	10		10.0	0.0
120	SH050	lidocaine 4% soln, topical (Xylocaine)	0.1733	ml				4			
121	SJ007	**bacitracin oint (0.9gm uou)**	0.1202	item						6.0	0.0
122	SJ010	basin, emesis	0.2415	item		1	-	1		1.0	0.0
123	SJ037	oxymetazoline nasal spray (Afrin) (15ml uou)	1.7025	item		1	-	1		1.0	0.0
124	SJ053	swab-pad, alcohol	0.0333	item		2	-	2		2.0	0.0
125	SA041	pack, basic injection	10.755	pack				1			
126	SA043	pack, cleaning, surgical instruments	10.7922	pack				1			
127	SL464	Atomizer tips (disposable)	0	item				1			
128	SM001	atomizer tip shield (RhinoGuard)	0.905	item				1			
129	SG074	steri-strip (6 strip uou)	1.434	item							
130	SG004	adhesive liquid (Mastisol) (0.67ml uou)	2.3415	item							
131	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
132		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 3.45**	**$ 1.33**	**$ 1.94**	**$ -**	**$ 2.45**	**$ 0.52**
133	EQ234	suction and pressure cabinet, ENT (SMR)	4032.9248	Default	0.010702279	93	36	49		66	14
134	EQ170	light, fiberoptic headlight w-source	3525.9372	Default	0.013970455	93	36	49		66	14
135	EF008	chair with headrest, exam, reclining	5565.6015	Default	0.01238009	93	36	49		66	14
136	EQ137	instrument pack, basic ($500-$1499)	500	Instrument Packs	0.002323783			55			
137											
138											
140											

	A	B	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**							
2			**21320**							
3		***RUC Collaboration Website***	Closed treatment of nasal bone fracture with manipulation; with stabilization							
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 5** **Specialty: AAO-HNS, ASPS**								
5		**LOCATION**	**Non Fac**	**Facility**						
6		**GLOBAL PERIOD**	**000**	**000**						
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$102.73**	**$ 5.55**						
8		**TOTAL CLINICAL STAFF TIME**	**73.0**	**15.0**						
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**18.0**	**15.0**						
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**52.0**	**0.0**						
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**0.0**						
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 27.01**	**$ 5.55**						
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	5	3						
16	CA002	Coordinate pre-surgery services (including test results)	3	3						
17	CA003	Schedule space and equipment in facility	0	3						
18	CA004	Provide pre-service education/obtain consent	7	3						
19	CA005	Complete pre-procedure phone calls and prescription	3	3						
20	CA006	Confirm availability of prior images/studies								
21	CA007	Review patient clinical extant information and questionnaire								
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)								
23										
26		*Other activity: please include short clinical description here and type new*								
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	3							
34	CA010	Obtain vital signs	5							
35	CA011	Provide education/obtain consent								
36	CA012	Review requisition, assess for special needs								
37	CA013	Prepare room, equipment and supplies	2							
38	CA014	Confirm order, protocol exam	0							
39	CA015	Setup scope (nonfacility setting only)								
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient								
41	CA017	Sedate/apply anesthesia	2							
42										
45		*2004 PE listed "review charts 2 minutes"*								
48		**Intra-service (of service period)**								
49	CA018	Assist physician or other qualified healthcare professional---directly	20							
50	CA019	Assist physician or other qualified healthcare professional---directly								
51	CA020	Assist physician or other qualified healthcare professional---directly								
52	CA021	Perform procedure/service---NOT directly related to physician work time								
55										
56		*Other activity: please include short clinical description here and type new*								
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	4							
61	CA023	Monitor patient following procedure/service, no multitasking								
62	CA024	Clean room/equipment by clinical staff	3							
63	CA025	Clean scope								
64	CA026	Clean surgical instrument package	10							
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions								
66	CA028	Review/read post-procedure x-ray, lab and pathology reports								
67	CA029	Check dressings, catheters, wounds	1							
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,								
69	CA031	Review examination with interpreting MD/DO								
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to								
71	CA033	Perform regulatory mandated quality assurance activity (service period)								
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs,								
73	CA035	Review home care instructions, coordinate visits/prescriptions	2							
74	CA036	Discharge day management	**n/a**							
75										
78		*Other activity: please include short clinical description here and type new*								
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	3							
85	CA038	Coordinate post-procedure services								
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**						
87		99211 16 minutes								
88		99212 27 minutes								
89		99213 36 minutes								
90		99214 53 minutes								
91		99215 63 minutes								
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**						
93										
96		*Other activity: please include short clinical description here and type new*								
99		**End: with last office visit before end of global period**								

	A	B	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**							
2			**21320**							
3		***RUC Collaboration Website***	Closed treatment of nasal bone fracture with manipulation; with stabilization							
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 5** **Specialty: AAO-HNS, ASPS**								
5		**LOCATION**	**Non Fac**	**Facility**						
6		**GLOBAL PERIOD**	**000**	**000**						
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$102.73**	**$ 5.55**						
8		**TOTAL CLINICAL STAFF TIME**	**73.0**	**15.0**						
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**18.0**	**15.0**						
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**52.0**	**0.0**						
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**0.0**						
100	**Supply Code**	**MEDICAL SUPPLIES**								
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 73.58**	**$ -**						
102	SA048	pack, minimum multi-specialty visit	1							
103	SB022	gloves, non-sterile								
104	SB027	gown, staff, impervious								
105	SB034	mask, surgical, with face shield	1							
106	SB044	underpad 2ft x 3ft (Chux)								
107	SB046	drape, sterile, split-sheet								
108	SC051	syringe 10-12ml								
109	SC080	needle, OSHA compliant (SafetyGlide)	1							
110	SD009	canister, suction	1							
111	SD132	tubing, suction, non-latex (6ft uou)	1							
112	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)	1							
113	SG031	cottonoid	4							
114	SG056	gauze, sterile 4in x 4in (10 pack uou)	1							
115	SG066	**packing, gauze w-petrolatum, 0.5in (6yd uou)**	**0**							
116	SG073	splint, adhesive nasal (Denver)	1							
117	SG088	**tape, foam, elastic, 2in (Microfoam)**	6							
118	SH025	cocaine 4% solution, topical								
119	SH049	lidocaine 2% w-epi inj (Xylocaine w-epi)	10							
120	SH050	lidocaine 4% soln, topical (Xylocaine)	4							
121	SJ007	**bacitracin oint (0.9gm uou)**								
122	SJ010	basin, emesis	1							
123	SJ037	oxymetazoline nasal spray (Afrin) (15ml uou)	1							
124	SJ053	swab-pad, alcohol	2							
125	SA041	pack, basic injection	1							
126	SA043	pack, cleaning, surgical instruments	1							
127	SL464	Atomizer tips (disposable)	1							
128	SM001	atomizer tip shield (RhinoGuard)	1							
129	SG074	steri-strip (6 strip uou)	1							
130	SG004	adhesive liquid (Mastisol) (0.67ml uou)	1							
131	**Equipment Code**	**EQUIPMENT**								
132		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 2.14**	**$ -**						
133	EQ234	suction and pressure cabinet, ENT (SMR)	54							
134	EQ170	light, fiberoptic headlight w-source	54							
135	EF008	chair with headrest, exam, reclining	54							
136	EQ137	instrument pack, basic ($500-$1499)	60							
137										
138										
140										

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Arthrodesis Decompression – Tab 6

In October 2020, the CPT Editorial Panel approved the revision of four codes describing arthrodesis, addition of two codes to report laminectomy, facetectomy, or foraminotomy during posterior interbody arthrodesis, lumbar to more appropriately identify the decompression that may be separately reported. A coding change application (CCA) was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure. The coding confusion stemmed from language ("other than for decompression") included in the descriptors for CPT codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and 63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to several codes to consistently use the term "interspace" instead of "level" or "segment."

In January 2021, the specialty societies surveyed the two new codes and indicated the existing code changes were editorial. The RUC expressed concern that the base codes were not surveyed with the two new add-on codes. Two of the codes (22630 and 22632) are from 1995 and the other two codes were last RUC reviewed in 2011 (22633 and 22634). The RUC could not accept the specialties' justification for only surveying the new codes. They questioned how, without the base codes being surveyed, do we have assurance the respondents followed instruction to only consider the work of the add-on codes. Moreover, CMS has made it clear that the Agency expects the base codes and add-on codes to be reviewed at the same time. **The RUC recommends that the entire family (CPT codes 22630, 22632, 22633, 22634, 63052 and 63053) be resurveyed for review at the April 2021 RUC meeting and that interim values be established for CPT codes 63052 and 63053.**

63052 ***Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 141 neurosurgeons and orthopaedic surgeons and determined that the survey 25th percentile work RVU of 5.55 appropriately accounts for the physician work involved in this add-on service. The RUC recommends 40 minutes intra-service time.

To justify a work RVU of 5.55, the RUC compared the survey code to the second key reference service code 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50 and 45 minutes intra-service time) and noted that the reference code has slightly higher intensity as anticipated for a surgical procedure as compared with a lumbar procedure. The RUC also compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13 and 40 minutes intra-service time) and noted that the

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

MPC code involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal abdominal aortic aneurysm (AAA). In comparison, exposure and closure for the survey code are performed as part of the primary arthrodesis code and the intra-service time includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, although both codes require the same time, the physician work and intensity of 63052 is greater than 34812.

For additional support, the RUC agreed that CPT code 63052 is appropriately bracketed by comparator codes 33924 *Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)* (work RVU = 5.49 and 30 minutes intra-service time) and 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 6.43 and 40 minutes intra-service time). CPT code 33924 takes less time but is significantly more intense than 63052, while the time and physician work for CPT code 22614 is like 63052. The RUC concluded that CPT code 63052 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends an interim work RVU of 5.55 for CPT code 63052.**

63053 ***Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 141 neurosurgeons and orthopaedic surgeons and determined that a direct work RVU crosswalk to CPT code 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)* (work RVU = 4.44 and 30 minutes intra-service time) accurately reflects the physician work necessary for this add-on service and falls below the survey 25th percentile. The RUC acknowledged the robust survey results yet questioned the 25th percentile value given the time for CPT code 63053 is three-fourths that of the 63052 code.

The RUC compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU = 4.13 and 40 minutes intra-service time) and noted that the MPC code involves more intra-service time and the physician work and intensity are greater for the survey code.

For additional support, the RUC agreed that CPT code 63053 is appropriately bracketed by comparator codes 32674 *Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)* (work RVU = 4.12 and 30 minutes intra-service time) and 33924 *Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)* (work RVU = 5.49 and 30 minutes intra-service time). CPT code 32674 is a minimally invasive procedure to identify and remove lymph nodes in conjunction with a single lobe lobectomy. The technical skill and mental effort/judgment for 63053 is greater due to the involvement and protection of spinal cord and neural elements. CPT code 33924 requires the same amount of time but is more intense than 63053.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC concluded that CPT code 63053 should be valued based on a direct crosswalk to CPT code 33572 with 30 minutes intra-service time as supported by both the crosswalk and the survey. **The RUC recommends an interim work RVU of 4.44 for CPT code 63053.**

Practice Expense
No direct practice expense inputs are recommended for CPT codes 63052 and 63053 as they are facility-based add-on services.

RUC Database Flag
The RUC recommends to flag CPT codes 63052 and 63053 as "Do Not Use to Validate for Physician Work" since the values are being assigned on an interim basis.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Arthrodesis **Posterior, Posterolateral or Lateral Transverse Process Technique** *To report instrumentation procedures, see 22840-22855, 22859. (Report in addition to code[s] for the definitive procedure[s].) Do not append modifier 62 to spinal instrumentation codes 22840-22848, 22850, 22852, 22853, 22854, 22859.* *To report bone graft procedures, see 20930-20938. (Report in addition to code[s] for the definitive procedure[s].) Do not append modifier 62 to bone graft codes 20900-20938.* **Corpectomy** identifies removal of a vertebral body during spinal surgery. **Facetectomy** is the excision of the facet joint between two vertebral bodies. There are two facet joints at each vertebral segment (see below) **Foraminotomy** is the excision of bone to widen the intervertebral foramen. The intervertebral foramen is bordered by the superior notch of the adjacent vertebra, the inferior notch of the vertebra, the facet joint and the intervertebral disc. **Hemilaminectomy** is removal of a portion of a vertebral lamina, usually performed for exploration of, access to, or decompression of the intraspinal contents. **Lamina** pertains to the vertebral arch, the flattened posterior portion of the vertebral arch extending between the pedicles and the midline, forming the dorsal wall of the vertebral foramen, and from the midline junction of which the spinous process extends. **Laminectomy** is excision of a vertebral lamina; commonly used to denote removal of the posterior arch. **Laminotomy** is excision of a portion of the vertebral lamina, resulting in enlargement of the intervertebral foramen for the purpose of relieving pressure ~~in~~ on a spinal nerve root.				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae. A vertebral interspace is the nonbony compartment between two adjacent vertebral bodies which contains the intervertebral disc, and includes the nucleus pulposus, annulus fibrosus, and two cartilaginous endplates. Decompression performed on the same vertebral segment(s) and/or interspace[s] as posterior lumbar interbody fusion that includes laminectomy, facetectomy, and/or foraminotomy may be separately reported using 63052, 63053. Decompression solely to prepare the interspace for fusion is not separately reported.				
(e)22600	-	Arthrodesis, posterior or posterolateral technique, single ~~level~~ interspace; cervical below C2 segment	090	17.40 (No Change)
(e)22610	-	thoracic (with lateral transverse technique, when performed)	090	17.28 (No Change)
(e)22612	-	lumbar (with lateral transverse technique, when performed) (Do not report 22612 in conjunction with 22630 for the same interspace ~~and segment~~, use 22633)	090	23.53 (No Change)
(e)+22614	-	each additional ~~vertebral segment~~interspace (List separately in addition to code for primary procedure) (Use 22614 in conjunction with 22600, 22610, 22612, 22630 or 22633 when performed for arthrodesis at a different ~~level~~ interspace. When performing a posterior or posterolateral technique for fusion/arthrodesis at an additional ~~level~~ interspace, use 22614. When performing a posterior interbody fusion arthrodesis at an additional ~~level~~ interspace, use 22632. When performing a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional ~~level~~ interspace, use 22634) (For facet joint fusion, see 0219T-0222T) (For placement of a posterior intrafacet implant, see 0219T-0222T)	ZZZ	6.43 (No Change)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(f)22630	J1	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar (Do not report 22630 in conjunction with 22612 for the same interspace and segment, use 22633)	090	22.09 (Interim RUC Recommendation) (Resurvey for April 2021)
(f)+22632	J2	each additional interspace (List separately in addition to code for primary procedure) (Use 22632 in conjunction with 22612, 22630, or 22633 when performed at a different ~~level~~ interspace. When performing a posterior interbody fusion arthrodesis at an additional ~~level~~ interspace, use 22632. When performing a posterior or posterolateral technique for fusion/arthrodesis at an additional ~~level~~ interspace, use 22614. When performing a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional ~~level~~ interspace, use 22634)	ZZZ	5.22 (Interim RUC Recommendation) (Resurvey for April 2021)
▲22633	J3	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace ~~and segment~~; lumbar (Do not report with 22612 or 22630 ~~at the~~ for the same ~~level~~ interspace)	090	27.75 (Interim RUC Recommendation) (Resurvey for April 2021)
+▲22634	J4	each additional interspace and segment (List separately in addition to code for primary procedure) (Use 22634 in conjunction with 22633) (Do not report 22630, 22632, 22633, 22634 in conjunction with 63030, 63040, 63042, 63047, 63056, 63052, 63053, for laminectomy performed to prepare the interspace on the same spinal interspace[s]) (To report decompression performed on the same interspace as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of	ZZZ	8.16 (Interim RUC Recommendation) (Resurvey for April 2021)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)		

Nervous System
Posterior Extradural Laminotomy or Laminectomy for Exploration/Decompression of Neural Elements or Excision of Herniated Intervertebral Discs

Definitions

For purposes of CPT coding . . .

63020 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical*

(For bilateral procedure, report 63020 with modifier 50)

63030 *1 interspace, lumbar*
(For bilateral procedure, report 63030 with modifier 50)

+63035 *each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)*

(Use 63035 in conjunction with 63020-63030)

(Do not report 63030, 63035 in conjunction with 22630, 22632, 22633, 22634 for laminotomy performed to prepare the interspace for fusion on the same spinal interspace)

(To report decompression performed on the same interspace and vertebral segment[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)

(For bilateral procedure, report 63035 twice. Do not report modifier 50 in conjunction with 63035)

(For percutaneous endoscopic approach, see 0274T, 0275T)

63040 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical*

63042 *lumbar*
(For bilateral procedure, report 63042 with modifier 50)

+63043 *each additional cervical interspace (List separately in addition to code for primary procedure)*
(Use 63043 in conjunction with 63040)
(For bilateral procedure, report 63043 twice. Do not report modifier 50 in conjunction with 63043)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Ê63044 *each additional lumbar interspace (List separately in addition to code for primary procedure)*

(Use 63044 in conjunction with 63042)

(Do not report 63040, 63042, 63043, 63044, in conjunction with 22630, 22632, 22633, 22634 for laminotomy to prepare the interspace for fusion on the same interspace and vertebral segment[s])

(To report decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)

(For bilateral procedure, report 63044 twice. Do not report modifier 50 in conjunction with 63044)

Decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, facetectomy, or foraminotomy may be separately reported using 63052.

Codes 63052, 63053 may only be reported for decompression at the same anatomic site(s) when posterior interbody fusion (eg, 22630) requires decompression beyond preparation of the interspace(s) for fusion.

63045 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical*

63046 *thoracic*

63047 *lumbar*

✚▲63048 each additional vertebral segment, cervical, thoracic or lumbar (List separately in addition to code for primary procedure

(Use 63048 in conjunction with 63045-63047)

(Do not report 63047, 63048 in conjunction with 22630, 22632, 22633, 22634 for laminectomy performed to prepare the interspace for fusion on the same vertebral segments and/or interspace[s])

(To report decompression performed on the same vertebral segments and/or interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

✎●63052	J5	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	ZZZ	5.55 (Interim RUC Recommendation) (Resurvey for April 2021)
+●63053	J6	each additional segment (List separately in addition to code for primary procedure) (Use 63053 in conjunction with 63052) (Use 63052, 63053 in conjunction with 22630, 22632, 22633, 22634)	ZZZ	4.44 (Interim RUC Recommendation) (Resurvey for April 2021)

63050 *Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;*

63051 *with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)*

Transpedicular or Costovertebral Approach for Posterolateral Extradural Exploration/Decompression

63055 *Transpedicular approach with decompression of spinal cord, equine and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic*

63056 *lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)*

+63057 *each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure*

(Use 63057 in conjunction with 63055, 63056)

(Do not report 63056, 63057 for a herniated disc, in conjunction with 22630, 22632, 22633, 22634 for decompression-to prepare the interspace on the same interspace[s])

(To report decompression performed on the same interspace[s] as posterior interbody fusion that includes laminectomy, removal of facets, or opening/widening of the foramen for decompression of nerves or spinal components such as spinal cord, cauda equina, or nerve roots, see 63052, 63053)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

December 11, 2020

Peter K. Smith, MD
Chair, AMA/Specialty Society RVS Update Committee
AMA Plaza
330 N Wabash Avenue, Suite 39300
Chicago, IL 60611-5885

Dear Dr. Smith,

A coding change application (CCA) was submitted to assist with coding confusion for reporting decompression with posterior/posterolateral fusion procedures. To clarify correct coding, two new add-on codes (63052 and 63053) were established to report decompression when performed in conjunction with posterior interbody arthrodesis. Many editorial changes were also made to guidelines, parenthetical instructions, and the terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined. Editorial code descriptor changes allowed for consistent use of the term "interspace" instead of "level" or "segment."

The LOI from the CPT meeting identified the two new add-on codes and codes 22630-22634 for survey. The American Academy of Orthopaedic Surgeons (AAOS), the American Association of Neurosurgeons (AANS), the Congress of Neurological Surgeons (CNS), the North American Spine Society (NASS), and the International Society for Advancement of Spine Surgery (ISASS) surveyed the new add-on codes 630XX and 630X1 but did not survey 22630-22634. The only change made to the descriptors for these codes was to editorially delete the words “and segment” after "interspace" in code 22633. This editorial change did not change the work of the code.

Codes 22630 and 22632 are legacy CPT codes (pre-1990). The work has not changed since the last time the RUC reviewed these codes. Codes 22633 and 22634 also represent legacy CPT codes that were revised for CPT 2012 to bundle work. The work has not changed since the last time the RUC reviewed these codes. The stakeholder societies do not agree that the expense and time for a survey of established procedures with an editorial "clean-up" of a single term are justified.

Thank you for considering our comments regarding the editorial changes made by the CPT Panel to codes 22630-22634.

Sincerely,

William R. Creevy, MD
AAOS RUC Advisor

Clemens Schirmer, MD
CNS RUC Advisor

Karin Swartz, MD
NASS RUC Advisor

Morgan Lorio, MD
ISASS RUC Advisor

John Ratliff, MD
AANS RUC Advisor

January 12, 2020

Peter K. Smith, MD
Chair, AMA/Specialty Society RVS Update Committee
AMA Plaza
330 N Wabash Avenue, Suite 39300
Chicago, IL 60611-5885

Dear Dr. Smith,

This letter responds to a request from AMA staff on January 11, 2021, asking that we add the current time and visit data to our Tab 6 Survey Summary Spreadsheet for four codes included in the Tab 6 LOI. We disagree that it is appropriate to place anything on our survey summary Excel spreadsheet other than the summary data from the survey we conducted for the new codes 63052 and 63053. We note that CMS recommended creating add-on codes for this work, and CMS never opined that the decompression work was included in 22630-22634.

We did not express an interest in surveying these codes or making a recommendation regarding work because the minor changes for these codes were editorial. We provided a letter to the RUC on December 12, 2020, that indicated the only difference was to delete the words “and segment” after "interspace" in code 22633 and to update terminology for consistency to replace the term "level" with "interspace" in related parentheticals. These were "clean up" changes proposed by the CPT Panel and not by the societies.

We hope that the RUC agrees that the coding changes to 22630-22634 were editorial. In that case, we respectfully suggest this information should be provided to CMS along with Work and PE recommendations for the two new codes. There are many instances in the RUC database where the RUC rationale sent to CMS states the code changes were editorial and did not change the work described by the code.

Thank you for considering our comments.

Sincerely,

William R. Creevy, MD
AAOS RUC Advisor

Clemens Schirmer, MD
CNS RUC Advisor

Karin Swartz, MD
NASS RUC Advisor
Advisor

Morgan Lorio, MD
ISASS RUC

John Ratliff, MD
AANS RUC
Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:63052 Tracking Number J5 Original Specialty Recommended RVU: **5.55**
Presented Recommended RVU: **5.55**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **5.55**

CPT Descriptor: Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)
(Use 63053 in conjunction with 63052)
(Use 63052, 63053 in conjunction with 22630, 22632, 22633, 22634)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During (separately reported) posterior lumbar interbody arthrodesis for L4-5 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 63-year-old female with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 level, requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention. Note: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s].

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: NA

Description of Intra-Service Work: Following bony and soft tissue resection and exposure of the L4-5 disc space for the interbody access and preparation for interbody arthrodesis, attention is turned to the additional bone and nervous system work required for decompression beyond what is required to access the disc space for the interbody arthrodesis. Additional portions of the laminae at the L4 and L5 vertebral segments are removed with a drill or bone biting instruments, and the inferior and superior facets are resected. The neural foraminae are expanded with bone biting instruments. The ligamentum flavum is dissected off the dura and completely removed, decompressing and mobilizing the neural elements. The neural elements are confirmed to be mobilized and decompressed. The additional work is documented in the medical record.

Description of Post-Service Work: NA

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	63052					
Sample Size:	1431	**Resp N:**	141			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	25.00	**50.00**	80.00	400.00	
Survey RVW:	3.50	5.55	**8.50**	12.75	28.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	10.00	21.00	**40.00**	50.00	365.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	63052	**Recommended Physician Work RVU: 5.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22840	ZZZ	12.52	**RUC Time**

CPT Descriptor Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22552	ZZZ	6.50	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 **% of respondents:** 19.1 **%**

Number of respondents who choose 2nd Key Reference Code: 24 **% of respondents:** 17.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 63052	Top Key Reference CPT Code: 22840	2nd Key Reference CPT Code: **22552**
Median Pre-Service Time	0.00	0.00	5.00
Median Intra-Service Time	40.00	60.00	45.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**40.00**	**60.00**	**50.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	22%	48%	30%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	30%	70%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	30%	67%
Physical effort required	19%	26%	56%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	19%	81%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	50%	38%	4%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	67%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	54%	38%
Physical effort required	8%	46%	46%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	54%	21%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background – 63052, 63053

A coding change application (CCA) was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure (please see supplemental file with an overview of historical reporting). The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and

63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to a number of codes to consistently use the term "interspace" instead of "level" or "segment."

The AANS, CNS, AAOS, NASS, and ISASS conducted a survey of the new add-on codes for reporting decompression when performed concurrently and at the same interspace with posterior interbody arthrodesis. The societies received a robust response from 141 surgeons with experience performing these procedures. Those few surgeons without experience in the past 12 months indicated experience within the past 5 years.

Recommendation – 63052

We recommend a work RVU of 5.55 for code 63052, which is the survey 25th percentile.

Pre-time and Post-time

The society expert panel did not survey for pre- and/or post-time for this add-on code as pre- and post-work would be performed as part of the primary procedure.

Key Reference Code Comparison

KRS1: Code 22840 may be reported with many procedures but is typically performed in conjunction with (separately reported) arthrodesis. The intensity and time for this procedure are driven by the precise nature of repairing deforming spondylopathies or dorsopathies using non-segmental instrumentation. The 27 respondents who chose 22840 as a reference believed 63052 was more intense/complex than 22840. This is possible given the variable nature of 22840 and the respondents' experience.

KRS2: Code 22552 is reported for each additional interspace anterior interbody arthrodesis for spondylopathies, spondylosis, or other cervical disc disorders. Similar to 63052, code 22552 is additional work to a primary fusion procedure; incisions, dissection, exposure, and closure are included in the primary procedure work. These add-on codes both only include intraoperative effort. The intensity/complexity comparison statistics correctly indicate that 22552 requires similar or slightly more mental effort/judgment, technical skill, and psychological stress when compared with 63052.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	12.52	0.209	60	0	60	0
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.55	0.139	40	0	40	0
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)	6.50	0.142	50	5	45	0

MPC Code Comparison

There are only 17 MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound, typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, exposure and closure for 63052 are performed as part of the primary arthrodesis code: Exposure of the contralateral vertebral body elements is routinely completed as part of the primary arthrodesis code. Code 63052 intra-service includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. Therefore, although both codes require the same time, the intensity of 63052 would be greater than 34812.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.55	0.139	40	0	40	0

Other Code Comparison

Codes 33924 and 22614 bracket and offer further support of the recommended wRVU of 5.55 for 63052. Code 33924 takes less time, but is significantly more intense than 63052. The time and work for code 22614 is similar to 63052.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
33924	Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)	5.49	0.183	30	0	30	0
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	5.55	0.139	40	0	40	0
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	6.43	0.161	40	0	40	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 63052 may be reported in conjunction with 22630 and 22633

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There has been no reporting mechanism for this work since 2015. Please see supplemental file with an historical reporting overview.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency data is not avaialable

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
11,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. specialty expert panel estimate

Specialty neurosurgery Frequency 5830 Percentage 53.00 %

Specialty orthopaedic surgery Frequency 5170 Percentage 47.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63066

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:63053 Tracking Number J6 Original Specialty Recommended RVU: **4.70**
Presented Recommended RVU: **4.70**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **4.44**

CPT Descriptor: Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)
(Use 63053 in conjunction with 63052)
(Use 63052, 63053 in conjunction with 22630, 22632, 22633, 22634)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During (separately reported) posterior lumbar interbody arthrodesis for L4-5 and L5-S1 spondylolisthesis with axial mechanical back pain and worsening neurogenic claudication and/or radiculopathy (extremity symptoms), refractory to nonoperative treatment, a 68-year-old male with advanced imaging that demonstrated central canal and bilateral lateral recess and foraminal stenosis at the L4-5 and L5-S1 levels requires bilateral laminectomy with extensive decompression of the cauda equina and/or nerve root[s]. This more extensive decompression is beyond the typical dissection needed to complete the interbody arthrodesis approach and intervention at each level. Note: This is an add-on service. Only consider the additional work related to bilateral laminectomy with decompression of the cauda equina and/or nerve root[s].

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: NA

Description of Intra-Service Work: After (separately reported) bony and soft tissue resection and exposure of the L4-L5 and L5-S1 disc spaces for the interbody access and preparation for arthrodesis is completed, along with the (separately reported) decompression of neural elements at the L4-L5 interspace, attention is turned to the additional bone and nervous system work required for decompression of the L5-S1 interspace beyond what is required to access the disc space for the interbody arthrodesis. Additional portions of the laminae at the L5 and S1 vertebral segments are removed with the drill or bone biting instruments, and the inferior and superior facets are resected. The neural foraminae are expanded with bone biting instruments. The ligamentum flavum is dissected off the dura and completely removed, allowing for decompression and mobilization ofand the neural elements are mobilized. The neural elements are confirmed to be mobilized and decompressed. The additional work is documented in the medical record.

Description of Post-Service Work: NA

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	John Ratliff MD, Clemens Schirmer MD, William Creevy MD, Hussein Elkousy MD, Karin Swartz MD, Morgan Lorio MD					
Specialty Society(ies):	AANS, CNS, AAOS, NASS, ISASS					
CPT Code:	63053					
Sample Size:	1431	**Resp N:**	141			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	8.00	**25.00**	54.00	350.00	
Survey RVW:	3.00	4.70	**6.50**	9.50	28.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	8.00	20.00	**30.00**	45.00	370.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	63053	**Recommended Physician Work RVU: 4.44**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22552	ZZZ	6.50	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22208	ZZZ	9.66	**RUC Time**

CPT Descriptor Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 24 **% of respondents:** 17.0 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 12.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 63053	Top Key Reference CPT Code: 22552	2nd Key Reference CPT Code: **22208**
Median Pre-Service Time	0.00	5.00	0.00
Median Intra-Service Time	30.00	45.00	120.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**50.00**	**120.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	13%	46%	38%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	75%	17%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	33%	58%
Physical effort required	4%	38%	58%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	54%	29%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	6%	44%	44%	6%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	61%	33%	6%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	33%	61%	6%
Physical effort required	28%	67%	6%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	28%	67%	6%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background – 63052, 63053

A coding change application (CCA) was created to assist with coding confusion for reporting additional decompression performed at the same interspace as a lumbar interbody fusion procedure (please see supplemental file with an overview of historical reporting). The coding confusion stemmed from language ("other than for decompression") included in the descriptors for codes 22630-22634. To clarify correct coding, the CCA created two new add-on codes (63052 and

63053) to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace, along with definitions, guidelines, and parenthetical instructions. The terms corpectomy, facetectomy, foraminotomy, hemilaminectomy, lamina, laminectomy, and laminotomy were defined and editorial changes were made to a number of codes to consistently use the term "interspace" instead of "level" or "segment."

The AANS, CNS, AAOS, NASS, and ISASS conducted a survey of the new add-on codes for reporting decompression when performed concurrently and at the same interspace with posterior interbody arthrodesis. The societies received a robust response from 141 surgeons with experience performing these procedures. Those few surgeons without experience in the past 12 months indicated experience within the past 5 years.

Recommendation – 63053

We recommend a work RVU of 4.70 for code 63053, which is the survey 25th percentile.

Pre-time and Post-time

The society expert panel did not survey for pre- and/or post-time for this add-on code as pre- and post-work would be performed as part of the primary procedure.

Key Reference Code Comparison

KRS1: Code 22552 is reported for each additional interspace anterior interbody arthrodesis for spondylopathies, spondylosis, or other cervical disc disorders. Similar to 63053, code 22552 is additional work to a primary fusion procedure; incisions, dissection, exposure, and closure are included in the primary procedure work. These add-on codes both only include intraoperative effort. The intensity/complexity comparison statistics correctly indicate that 22552 requires similar mental effort/judgment and psychological stress when compared with 63053. Technical skill and physical effort are greater for 63053.

KRS2: Code 22208 is reported for osteotomies that go through all three columns of the spine via a posterior approach in conjunction with other procedures to address scoliosis and kyphosis. This add-on procedure includes extending the incision of the primary procedure and additional dissection along the spinous process, lamina, and transverse processes before osteotomies are performed, this work which is typically performed bilaterally is tedious and takes a significant amount of time.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)	6.50	0.142	50	5	45	0
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	4.70	0.157	30	0	30	0
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)	9.66	0.078	135	0	120	15

MPC Code Comparison

There are only 17 MPC codes with a ZZZ global assignment which makes finding appropriate MPC codes with similar intensity/complexity difficult. MPC code 34812 (with the highest wRVU) involves open femoral artery exposure by groin incision and closure of the wound typically for separately reported delivery of an endovascular prosthesis for an asymptomatic infrarenal AAA. In comparison, exposure and closure for 63053 is performed as part of the primary arthrodesis code: Exposure of the contralateral vertebral body elements is routinely completed as part of the primary arthrodesis code. Code 63053 intra-service includes bony and soft tissue resection (typically pathologic and not normal in nature) and decompression of neural elements in immediate high-risk proximity of the pathologic anatomy. This would account for a higher intensity for 63053 when compared with 34812.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.13	0.103	40	0	40	0
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	4.70	0.157	30	0	30	0

Other Code Comparison

Codes 33924 and 32674 bracket and offer further support of the recommended wRVU of 4.70 for 63053. Code 32674 is a minimally invasive procedure to identify and remove lymph nodes in conjunction with a single lobe lobectomy. The technical skill and mental effort/judgment for 63053 is greater due to the involvement and protection of spinal cord and neural elements. Code 33924 requires the same amount of time, but is more intense than 63053.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
32674	Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)	4.12	0.137	30	0	30	0
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)	4.70	0.157	30	0	30	0
33924	Ligation and takedown of a systemic-to-pulmonary artery shunt, performed in conjunction with a congenital heart procedure (List separately in addition to code for primary procedure)	5.49	0.183	30	0	30	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 63053 is reported in conjunction with 22632 and 22634

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) There has been no reporting mechanism for this work since 2015. Please see supplemental file with an historical reporting overview.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency data is not avaialable

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty expert panel estimate

Specialty neurosurgery Frequency 2120 Percentage 53.00 %

Specialty orthopaedic surgery Frequency 1880 Percentage 47.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Explor/Decompr/Excis disc

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63066

+63052 and +63053: Historical Reporting Overview

Coding History

In the 1990's, the work for arthrodesis and decompression was typically performed jointly by an orthopedic surgeon who would perform the arthrodesis and a neurosurgeon who would perform the decompression. Perhaps the single most important aspect of this coding was that the decompression and arthrodesis was being coded at the same spinal level. The codes were surveyed in that manner, and wRVUs were based on each surgeon's work.

In 1998, an AMA CPT workgroup that convened to discuss reporting correct coding for spine procedures via an anterior approach, also reviewed the lumbar interbody fusion code (22630) and decompression code (63047) and determined that each code may be separately and discretely performed and that there was no overlap in intra-service work. The workgroup also agreed that each code was valued based on the specific work of each code (ie, interbody fusion versus decompression). For CPT 2000, the CPT Panel introduced language into code 22630 which made this point clear: “minimal laminectomy and/or discectomy to prepare the interspace.” The spirit of that language continues to this day in the parenthetical “other than for decompression.” That particular position was reinforced in the January 2001 *CPT Assistant* where a case illustration of a patient requiring a decompression and an interbody fusion was presented and the statement made, “63047-51 should be reported in addition to the code 22630.”

In 2012, in recognition that posterolateral fusions were commonly performed along with interbody fusions, a new bundled code (22633) was established to include the work of interbody fusions (22630) and posterolateral fusions (22612) being bundled together into 22633. It is important to note that the decompression element of the operation (63047) remained a separate entity as intended by the initial valuation of that code and the inclusion of ("other than for decompression") in the code descriptor.

In 2014, confusion, both at education seminars and in print, about correct coding of the additional work of laminectomy persisted, with societies not agreeing on appropriate coding for the additional work of decompression performed concurrently with interbody fusion.

In January 2015, due to misinformed educational materials, CMS took a drastic departure from the application of the CPT codes that had been in place for decades; specifically, the evolution of the codes, the validated surveys for each of the separate codes, and valuation of separate work, by establishing NCCI edits: *"CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy…; lumbar) or 63047 (laminectomy…; lumbar) with CPT codes 22630 or 22633 (arthrodesis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047."* [Chapter 4 of the NCCI manual]

In September 2015, the stakeholder societies conducted discussions with NCCI (CMS) about the history and valuation of codes 22630-22634. NCCI staff communicated that CMS had no intention to modify its position on these code pairs and instead recommended proposing an add-on code for use with arthrodesis codes that would describe additional decompression when performed.

Overview of CPT Assistant

After the coding changes for CPT 2000, the following CPT Assistant article was published that describes correct reporting of 22630 and 63047 for the same interspace.

January 2001 page 12
Coding Consultation
Musculoskeletal System, Surgery, 22554, 22630, 63001-63048, 63075-63078 (Q&A)

Question: The descriptors of codes 22554 and 22630 describe anterior (22554) or posterior (22630) interbody technique arthrodeses to include laminectomy, and/or diskectomy to prepare the interspace (other than for decompression). In what procedural circumstance would the 63001-63048 code(s) be reported in addition to code 22630? Similarly, in what procedural circumstance would code(s) 63075-63078 be reported in addition to code 22554?

AMA Comment
For both codes 22554 and 22630…

To report code 22554…

To report code 22630, *Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; lumbar*, in addition to code 63047-51, *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar*, again additional procedure(s) must have been performed. For example, in spinal procedures performed on patients having lateral lumbar stenosis, the surgeon may need to perform additional work above and beyond that described by the PLIF, including facetectomy(ies) and/or foraminotomy(ies), to adequately decompress the nerve roots. For the purpose of this example, code 63047-51 should be reported in addition to code 22630.

Regarding the issue of laterality…

To further clarify, code 22630 may also require the additional performance of a posterior fusion, which involves bone grafting and placement of posterior instrumentation. These procedures should be additionally reported. If the surgeon uses a threaded bone dowel or prosthetic device in the disk space, then code +22851 should be reported. If any other type of bone graft is performed, the appropriate bone graft code should be reported.

The anterior fusion procedure described by code 22554…

In 2016, AMA CPTA staff drafted a FAQ based on the NCCI edit that was established. The stakeholder societies were not contacted about this FAQ. If we had been contacted, we would have informed AMA staff that we were in the process of discussions with CMS about coding misinformation.

October 2016 page 11
Frequently Asked Questions: Surgery: Nervous System

Question: The procedures described in code 63047 was performed for decompression, which was documented in the operative note. In addition, the procedure described in code 22633 was also performed at the same interspace. How should this be reported?

Answer: Codes 63047 and 22633 cannot be reported for the same interspace. However, it is appropriate to report codes 63047, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar, and 22633, Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should be appended to indicate that these are two distinct procedures.

The October 2016 FAQ added considerable coding confusion and after much effort by the stakeholder societies, including presentation of the historical information in this document, CPTA published a coding correction.

> **May 2018 page 9**
> **Coding Correction: Reporting Codes 22633 and 63047**
>
> In the Frequently Asked Questions (FAQ) section (page 11) of the October 2016 issue of CPT® Assistant, the Surgery: Nervous System answer incorrectly stated that codes 22633, Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar, and 63047, Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar, may not be reported for the same interspace. On further analysis of this issue, it was demonstrated that this recommendation was inconsistent with previously published CPT® Assistant advice, which is that codes 22633 and 63047 may be reported for the same interspace when additional work is required to complete a decompression at a single spinal level. It is also appropriate to report codes 22633 and 63047, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should then be appended to indicate that these are two distinct procedures.
>
> This correction aligns the coding advice with historical precedent published prior to the incorrect revisions in advice given in the October 2016 FAQ.
>
> The following is the corrected coding advice:
>
> *Surgery: Nervous System*
> Question: The procedure described in code 63047 was performed for decompression, which was documented in the operative note. In addition, the procedure described in code 22633 was also performed at the same interspace. How should this be reported?
>
> Answer: Codes 22633 and 63047 may be reported for the same interspace when additional work is required to complete a decompression at a single spinal level. It is also appropriate to report codes 22633 and 63047, if the two procedures are performed at different interspaces. Modifier 59, Distinct Procedural Service, should then be appended to indicate that these are two distinct procedures.

We appreciate that CPT recognized and corrected an errant FAQ.

Summary

Since the establishment of the CCI edits in 2015, surgeons have not been allowed to report 63047 with 22630-22634 for the same interspace. **This document is meant to explain why the current utilization for decompression at the same interspace is "zero."**

The new add-on codes respond to CMS's direction (via NCCI correspondence) that recommends establishing an add-on code for use with arthrodesis codes that would describe additional decompression when performed.

In addition to creation of the add-on codes, numerous new definitions and two instructional guidelines specify when 63052 and 63053 correctly apply:

> Decompression performed on the same vertebral segment(s) and/or interspace[s] as posterior lumbar interbody fusion that includes laminectomy, facetectomy, and/or foraminotomy may be separately reported using 63052, 63053.
>
> Decompression solely to prepare the interspace for fusion is not separately reported.

ISSUE: Arthrodesis Decompression

TAB: 6

							RVW					Total	PRE	INTRA					POST	12 Month Svy Experience				
SOURCE	CPT	Glob	DESC	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	MIN	25th	MED	75th	MAX	P-SD	MIN	25th	MED	75th	MAX
REF1	22840	ZZZ	Posterior non-segmental instrumentation (eg, Ha	27	0.209	0.209			12.52			60	0			60			0					
REF2	22552	ZZZ	Arthrodesis, anterior interbody, including disc spa	24	0.142	0.130			6.50			50	5			45			0					
current			NEW		n/a	n/a																		
SVY	63052	ZZZ	Laminectomy, facetectomy, or foraminotomy (un	141	0.213	0.213	3.50	5.55	8.50	12.75	28.00	40	0	10	21	40	50	365	0	0	25	50	80	400
REC	63052	ZZZ	25th pctl		0.139	0.139			5.55			40	0			40			0					

REF1	22552	ZZZ	Arthrodesis, anterior interbody, including disc spa	24	0.142	0.130			6.50			50	5			45			0					
REF2	22208	ZZZ	Osteotomy of spine, posterior or posterolateral a	18	0.078	0.072			9.66			135	0			120			15					
current			NEW		n/a	n/a																		
SVY	63053	ZZZ	Laminectomy, facetectomy, or foraminotomy (un	141	0.217	0.217	3.00	4.70	6.50	9.50	28.00	30	0	8	20	30	45	370	0	0	8	25	54	350
CRWLK	33572	ZZZ	Coronary endarterectomy, open, any method		0.148	0.148			4.44			30	0			30			0					
REC	63053	ZZZ			0.148	0.148			4.44			30	0			30			0					

December 11, 2020

Scott Manaker, MD
Chair, AMA/RUC Practice Expense Subcommittee
American Medical Association
330 N. Wabash Avenue
Chicago, Illinois 60611

RE: Tab 6 Practice Expense

Dear Dr. Manaker,

The undersigned societies do not recommend clinical staff time, supplies or equipment for Tab 6 facility-only add-on codes 63052 and 63053.

Thank you,

John Ratliff, MD
AANS RUC Advisor

Karin Swartz, MD
NASS RUC Advisor

Clemens Schirmer, MD
CNS RUC Advisor

Morgan Lorio, MD
ISASS RUC Advisor

William R. Creevy, MD
AAOS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Percutaneous Cerebral Embolic Protection – Tab 7

In October 2020, the CPT Editorial Panel created a new add-on code to report transcatheter placement and subsequent removal of cerebral embolic protection device(s) and added instructions to report the new code in the Aortic Valve guidelines.

33370 ***Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 35 interventional cardiologists and agreed that the survey respondents, with a 25th percentile work value of 3.43, overvalued the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 34713 *Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)* (work RVU= 2.50, intra-service and total time of 20 minutes) would be appropriate, as both add-on services typically involve an identical amount of time and physician work intensity to perform. The RUC recommends 20 minutes of intra-service time.

The specialties noted that this new CPT code represents new technology enabling the capture and removal of debris that can dislodge during TAVR procedures. During the TAVR procedure, dislodged embolic debris may include pieces of arterial wall, valve tissue, calcified and foreign material, and both acute and organizing thrombus. Even small pieces can block blood flow to middle cerebral arteries and more distal tributaries in the brain, potentially leading to peri-procedural (≤ 72 hours) stroke or other neurological impairments, with devastating long-term consequences. Code 33370 includes percutaneous arterial (eg, right radial or femoral) access, placement of a guiding catheter, and delivery of the embolic protection filter(s) prior to the procedure. Placement of additional/multiple filters is not separately reportable. Code 33370 includes removal of the filter(s) and debris, removal of the arterial sheath, and closure of the arteriotomy by pressure and application of an arterial closure device or standard closure of the puncture by suture, as well as all imaging guidance and radiological supervision and interpretation associated with performing the service.

The specialties noted that unlike the underlying TAVR procedure that would be performed by a co-surgeon team (an interventional cardiologist and a cardiac surgeon), the transcatheter placement and subsequent removal of a cerebral embolic protection device would only be performed and reported by one provider, the interventional cardiologist. Therefore, this service would not be reported with the 62 co-surgeon CPT modifier.

The specialties also noted, and the RUC concurred, that this is an intense service to perform. The specialties noted that positioning and deploying the filters and retrieving them under fluoroscopy is very intense work for the interventional cardiologist as, during this time, trauma from the device itself could potentially dislodge debris causing stroke which it was intended to prevent.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Furthermore, the specialties confirmed that placement of additional/multiple filters is not separately reportable.

For additional support for a work value of 2.50, the RUC compared the survey code to MPC code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09 and intra-service time of 15 minutes) and noted that the survey code involves 5 more minutes of intra-service time and both services involve similar intensity. **The RUC recommends a work RVU of 2.50 for CPT code 33370.**

Affirmation of RUC Recommendations
CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 were surveyed in April 2018 and approved by CMS for the CPT 2020 cycle. Add-on codes 33367, 33368 and 33369 were surveyed in February 2012 and approved by CMS for the CPT 2013 cycle; these three services had their values affirmed by the RUC and CMS for the CPT 2020 cycle. The specialties noted that the new cerebral embolic protection service does not alter the underlying work of the TAVR. The RUC noted that the times, work values and direct PE inputs for these existing services continue to be appropriate. **The RUC affirms the work RVU of 22.47 for CPT code 33361, the work RVU of 24.54 for CPT code 33362, the work RVU of 25.47 for CPT code 33363, the work RVU of 25.97 for CPT code 33364, the work RVU of 26.59 for CPT code 33365, the work RVU of 29.35 for CPT code 33366, the work RVU of 11.88 for CPT code 33367, the work RVU of 14.39 for CPT code 33368 and the work RVU of 19.00 for CPT code 33369.**

Practice Expense
The RUC affirms the direct practice expense inputs for CPT codes 33361-33369. No direct practice expense inputs are recommended for CPT code 33370 as it is a facility-based add-on service.

New Technology/New Service
The RUC recommends that 33370 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Cardiovascular System** **Heart and Pericardium** **Cardiac Valves** **Aortic Valve**				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Codes 33361, 33362, 33363, 33364, 33365, 33366 are used to report transcatheter aortic valve replacement (TAVR)/transcatheter aortic valve implantation (TAVI). TAVR/TAVI requires two physician operators and all components of the procedure are reported using modifier 62.

Codes 33361, 33362, 33363, 33364, 33365, 33366 include the work, when performed, of percutaneous access, placing the access sheath, balloon aortic valvuloplasty, advancing the valve delivery system into position, repositioning the valve as needed, deploying the valve, temporary pacemaker insertion for rapid pacing (33210), and closure of the arteriotomy when performed. Codes 33361, 33362, 33363, 33364, 33365, 33366 include open arterial or cardiac approach.

Angiography, radiological supervision, and interpretation performed to guide TAVR/TAVI (eg, guiding valve placement, documenting completion of the intervention, assessing the vascular access site for closure) are included in these codes.

Add-on code 33370 may be reported for cerebral embolic protection in conjunction with TAVR/TAVI codes 33361, 33362, 33363, 33364, 33365, 33366. Code 33370 includes percutaneous arterial (eg, right radial or femoral) access, placement of a guiding catheter, and delivery of the embolic protection filter(s) prior to the procedure. Placement of additional/multiple filters is not separately reportable. Code 33370 includes removal of the filter(s) and debris, removal of the arterial sheath, and closure of the arteriotomy by pressure and application of an arterial closure device or standard closure of the puncture by suture. Extensive repair or replacement of an artery may be additionally reported. Code 33370 includes all imaging guidance and radiological supervision and interpretation associated with performing cerebral embolic protection (eg, 75600, 75710, 76937).

Diagnostic left heart catheterization codes (93452, 93453, 93458-93461) and the supravalvular aortography code (93567) should not be used with TAVR/TAVI services (33361, 33362, 33363, 33364, 33365, 33366) to report.

(f)33361	K1	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	000	22.47 (Affirmed April 2018 RUC Recommendation)
(f)33362	K2	open femoral artery approach	000	24.54 (Affirmed April 2018 RUC Recommendation)
(f)33363	K3	open axillary artery approach	000	25.47 (Affirmed April 2018 RUC Recommendation)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(f)33364	K4	open iliac artery approach	000	25.97 (Affirmed April 2018 RUC Recommendation)
(f)33365	K5	transaortic approach (eg, median sternotomy, mediastinotomy)	000	26.59 (Affirmed April 2018 RUC Recommendation)
(f)33366	K6	transapical exposure (eg, left thoracotomy)	000	29.35 (Affirmed April 2018 RUC Recommendation)
(f)✚33367	K7	cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure) (Use 33367 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33477, 0483T, 0484T, 0544T, 0545T, 0569T, 0570T, 0X18T) (Do not report 33367 in conjunction with 33368, 33369) (For cerebral embolic protection, use 33370)	ZZZ	11.88 (Affirmed April 2012 RUC Recommendation)
(f)✚33368	K8	cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure) (Use 33368 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33477, 0483T, 0484T, 0544T, 0545T, 0569T, 0570T, 0X18T) (Do not report 33368 in conjunction with 33367, 33369)	ZZZ	14.39 (Affirmed April 2012 RUC Recommendation)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(f)✚33369	K9	cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure) (Use 33369 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33477, 0483T, 0484T, 0544T, 0545T, 0569T, 0570T, 0X18T) (Do not report 33369 in conjunction with 33367, 33368)	ZZZ	19.00 (Affirmed April 2012 RUC Recommendation)
✚●33370	K10	Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure) (Use 33370 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366)	ZZZ	2.50

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33370 Tracking Number K10 Original Specialty Recommended RVU: **3.43**
Presented Recommended RVU: **3.43**
Global Period: ZZZ Current Work RVU: **N/A** RUC Recommended RVU: **2.50**

CPT Descriptor: Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (list separately in addition to code for primary procedure) (Use 33370 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a TAVR/TAVI procedure, a 76-year-old male with prior transient ischemic attack (TIA)/cerebrovascular accident (CVA) and critical aortic valve stenosis also requires the addition of a cerebral embolic protection device to be placed prior to the tavr/tavi and removed after the TAVR/TAVI procedure. Note: This is an add-on service. only consider the additional work related to the cerebral embolic protection device.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Assess stroke risk and baseline neurologic status of patient. Assessment of technical difficulty and risk. Review CTA to evaluate patient specific anatomy of brachiocephalic artery, Aortic Arch and origin and course of Left Common Carotid Artery. Evaluate for plaque and calcium burden of great vessel, another origin. Insertion of radial artery sheath. Insertion of CEP device: naviagate brachial, axillary and brachiocephalic arteries. Position guide wire in the ascending aorta. Deploy proximal filter in Brachiocephalic artery. Flex articulation of distal segment of the device and direct guide wire into the Left Common Carotid artery. Advance and deploy distal filter. Removal of device: Both filters are withdrawn into the device to capture the embolic debris. Withdraw device from vasculature. Removal of radial sheath, place TR band for hemostasis. Ensure adequacy of hand circulation. Evaluate efficacy of device: Flush filters and evaluate captured debris. Neurocognitive assessment. Access site evaluation.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Edward Toggart, MD, FSCAI; Lloyd Klein, MD, FSCAI; Ricard Wright, MD, FACC; Thad Waites, MD, FACC, Edward Tuohy, MD					
Specialty Society(ies):	American College of Cardiology, Society for Cardiovascular Angiography and interventions.					
CPT Code:	33370					
Sample Size:	2000	**Resp N:**	35			
Description of Sample:	Random SCAI domestic members and ACC interventionalists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	19.00	250.00
Survey RVW:	1.60	3.43	**4.15**	5.00	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	14.00	**20.00**	25.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	33370	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36228	ZZZ	4.25	**RUC Time**

CPT Descriptor Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93462	ZZZ	3.73	**RUC Time**

CPT Descriptor Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	16,995,142

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36227	ZZZ	2.09	**RUC Time**	1,447,490

CPT Descriptor 2 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 22 **% of respondents:** 62.8 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 17.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 33370	Top Key Reference CPT Code: 36228	2nd Key Reference CPT Code: 93462
Median Pre-Service Time	0.00	0.00	10.00
Median Intra-Service Time	20.00	30.00	30.00
Median Immediate Post-service Time	0.00	0.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**30.00**	**50.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	18%	18%	45%	18%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	35%	18%	55%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	14%	32%	54%

Physical effort required	5%	45%	50%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	36%	54%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	83%	17%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	67%	33%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	17%	33%	50%
Physical effort required	33%	66%	0%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

In October 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel on code 33370. A new Category I CPT code was needed to capture the additional physician work associated with delivering and retrieving

cerebral embolic protection used during TAVR. New technology allows for the capture and removal of debris that can dislodge during TAVR procedures. During the TAVR procedure, dislodged embolic debris may include pieces of arterial wall, valve tissue, calcified and foreign material, and both acute and organizing thrombus. Even small pieces can block blood flow to middle cerebral arteries and more distal tributaries in the brain, potentially leading to peri-procedural (≤ 72 hours) stroke or other neurological impairments, with devastating long-term consequences.

Add-on code 33370 may be reported for cerebral embolic protection in conjunction with TAVR/TAVI codes 33361, 33362, 33363, 33364, 33365, 33366. Code 33370 includes percutaneous arterial (eg, right radial or femoral) access, placement of a guiding catheter, and delivery of the embolic protection filter(s) prior to the procedure. Placement of additional/multiple filters is not separately reportable. Code 33370 includes removal of the filter(s) and debris, removal of the arterial sheath, and closure of the arteriotomy by pressure and application of an arterial closure device or standard closure of the puncture by suture. Extensive repair or replacement of an artery may be additionally reported. Code 33370 includes all imaging guidance and radiological supervision and interpretation associated with performing cerebral embolic protection (eg, 75600, 75710, 76937).

The ACC and SCAI randomly surveyed cardiac interventionalists and as designated by membership rolls, on the newly created code. The ZZZ-global day survey was completed by physicians who have experience with the service.

The key reference code is 36228 for selective catheter placement. It was selected by approximately 63% of respondents. 63% of the respondents indicated that 33370 was more complex. The second reference code was 93462 for left heart catheterization. It was selected by approximately 17 % of respondents. About 17% of the respondents indicated that 33370 was more intense/complex overall.

Recommendation

Therefore, for code 33370 the **societies recommend the survey median RVW of 3.43 with 20 minutes intraservice time**. This value is lower than the KRS, but still correctly produces a higher IWPUT based on those respondents intensity/complexity comparison. It is also higher than another percutaneous code that also has 20 minutes intraservice, 34713 for access and closure of femoral artery. 33370 requires establishing a new arterial access via the right radial artery and there is no guide catheter directing the device to the appropriate position, further supporting the value.

Reaffirmation

Finally, TAVR codes 33361-33369 were included in the survey packet for Tab 7. The main TAVR code, 33361, and its other percutaneous siblings 33362-33363 were reviewed by the RUC after great deliberation about the use of extant data at the April 2018 meeting. Bypass TAVR codes 33367-33369 remain miniscule in utilization and were originally reviewed in 2012. The societies recommend reaffirmation of these values. Cerebral embolic protection does not alter the underlying work of the TAVR.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and

accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Cardiac Surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Double the 2019 Medicare utilization below, which would include MA plans and also some commercial insurance now that TAVR is performed in low-risk patients.

Specialty Cardiology Frequency 28500 Percentage 95.00 %

Specialty Cardiac Surgery Frequency 1500 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. As retrieved by Medicare SAF file data, in 2018 the cerebral embolic protection procedure was performed in 39 states across the US, in approximately 137 hospitals. In 2019, this procedure was used in 47 states in 256 facilities. This estimate is roughly one third of TAVRs perfomred in 2019, as roughly one third of facilities used the device in 2019.

Specialty Cardiology Frequency 14250 Percentage 95.00 %

Specialty Cardiac Surgery Frequency 750 Percentage 5.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33361

SS Rec Summary

ISSUE: Percutaneous Cerebral Embolic Protection (33370, 33361-69)

TAB: 7

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	36228	ZZZ	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)	22	0.142	0.142			4.25			30						30																
2nd REF	93462	ZZZ	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	6	0.093	0.093			3.73			40						40																
CURRENT	93799		Unlisted cardiovascular service or procedure		N/A	N/A						0																					
SVY	33370	ZZZ	Transcatheter placement and subsequent removal of / cerebral embolic protection device(s), including arterial / access, catheterization, imaging, and radiological / supervision and interpretation, percutaneous (list / separately in addition to code for primary procedure) / (use 33370 in conjunction with 33361, 33362, 33363, / 33364, 33365, 33366)	35	0.208	0.208	1.60	3.43	4.15	5.00	10.00	20	0	0	0	4	14	20	25	90								0	0	5	19	250
REC	33370	ZZZ	Transcatheter placement and subsequent removal of / cerebral embolic protection device(s), including arterial / access, catheterization, imaging, and radiological / supervision and interpretation, percutaneous (list / separately in addition to code for primary procedure) / (use 33370 in conjunction with 33361, 33362, 33363, / 33364, 33365, 33366)		0.125	0.125			2.50			20						20			0											
CRSWLK	34713	ZZZ	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)		0.125	0.125			2.50			20						20			0										
CURRENT	33361	000	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach		0.174	0.082			22.47			275	50	15	20			90			30	1										
Affirm previous RUC recommendations																																
CURRENT	33362	000	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach		0.169	0.081			24.54			303	50	15	20			103			45	1										
Affirm previous RUC recommendations																																
CURRENT	33363	000	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach		0.183	0.085			25.47			300	50	15	20			100			45	1										
Affirm previous RUC recommendations																																
CURRENT	33364	000	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach		0.201	0.088			25.97			294	50	15	20			94			45	1										
Affirm previous RUC recommendations																																
CURRENT	33365	000	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)		0.162	0.083			26.59			320	50	15	20			120			45	1										
Affirm previous RUC recommendations																																
CURRENT	33366	000	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)		0.185	0.092			29.35			320	50	15	20			120			45	1										
Affirm previous RUC recommendations																																
CURRENT	33367	ZZZ	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)		0.132	0.132			11.88			90		0				90			0											
Affirm previous RUC recommendations																																
CURRENT	33368	ZZZ	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)		0.120	0.120			14.39			120		0				120			0											
Affirm previous RUC recommendations																																
CURRENT	33369	ZZZ	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)		0.119	0.119			19.00			160		0				160			0											
Affirm previous RUC recommendations																																

December 14, 2020
Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Tab 8 Percutaneous Cerebral Embolic Protection

Dear Dr. Manaker:

Tab 7 on the January 2021 RUC agenda addresses one new ZZZ code, which describe Percutaneous Cerebral Embolic Protection procedures performed in conjunction with heart valve repair and replacement procedures. As such, we recommend no direct practice expense inputs for Tab 7.

Thank you for your consideration of this information as you prepare for the meeting. Please contact Wayne Powell at wpowell@scai.org or Claudia Vasquez at cvasquez@acc.org if you have any questions.

Sincerely,

/s/

Richard Wright, MD
ACC RUC Advisor

/s/
Edward Toggart, MD
SCAI RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
New Technology/New Services

April 2018

Transcatheter Aortic Valve Replacement (TAVR)

In 2005, the RUC began the process of flagging services that represent new technology or new services as they were presented to the Committee. In October 2016, the Relativity Assessment Workgroup reviewed codes that were flagged October 2011 – April 2012, with 3 years of available Medicare claims data (2013, 2014 and preliminary 2015 data). The Workgroup determined that the technology for these transcatheter aortic valve replacement (TAVR) services is evolving, as 400 cardiology centers now provide these services and have shifted from being provided in academic centers to now private centers. The RUC recommended that CPT codes 33361-33366 be resurveyed for physician work and practice expense. The RUC did not believe there would be a change in physician work or practice expense for the add-on services and recommends that CPT codes 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.

At the October 2017 RUC meeting, the specialty societies requested that this item be tabled and sent to the Research Subcommittee to develop a methodology that can be used to help value this unique set of codes which mandates the participation of two physicians and modifier 62 for the procedure. The specialties outlined their concerns with valuing these codes using the current methodology during the discussion with the pre-facilitation committee and the RUC. These are currently the only codes in the fee schedule where the -62 co-surgeon modifier is required 100 percent of the time. As each co-surgeon receives 62.5% of the work value and also each of them is performing the service and post-operative visit concurrently, the specialties noted this requirement has a direct impact on accurate valuation and interpretation of code components (various types of work per unit time; time spent by each provider) which makes valuing them difficult. Furthermore, the specialties noted that the Research Subcommittee and the RUC had previously approved the TVT registry as an extant data source and it was unclear to them how specifically these data points would be used in conjunction with the RUC survey data.

The RUC agreed to take no action on these codes at the October 2017 meeting and table their review until the April 2018 RUC meeting to provide the specialties and the Research Subcommittee sufficient time to resolve these methodologic issues. During the RUC's other business discussion, the RUC agreed that specialties should provide both median and mean for extant data sources as these summary data would provide the RUC with a more complete picture of central tendency. Providing both median and mean would provide information as to whether the dataset is negatively or positively skewed and to what degree.

Prior to the January 2018 RUC meeting, the specialty societies submitted a letter with a series of questions to be discussed by the Research Subcommittee. At the January 2018 Research Subcommittee meeting, the Subcommittee had a discussion with presenters from the Society of

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Thoracic Surgeons (STS), American College of Cardiology (ACC), American Association for Thoracic Surgery (AATS) and the Society for Cardiovascular Angiography and Interventions (SCAI) addressing their questions.

The Research Subcommittee made the Following Recommendations/Decisions at the January 2018 meeting:

- The Research Subcommittee did not approve any modification to the survey instrument or the survey data to simulate the payment adjustment created by the 62 co-surgeon modifier. The Subcommittee did note that that after following the standard RUC survey process the specialty societies may provide additional rationale to support their recommendation.

- The Research Subcommittee recommends the RUC continue to require a RUC survey and presentation of survey data from RUC-approved extant databases. The Subcommittee noted that data from the RUC-approved extant database may be used to support the advisory committees' recommendation.

- The Research Subcommittee recommends the RUC continue requiring both the mean and the median physician times from RUC-approved extant databases. The Subcommittee noted that the specialty societies may provide rationale on why one value is preferable to another on a case-by-case basis. The Subcommittee clarified that it is not within their purview to indicate how the RUC will use these data.

000-day Global Major Surgical Procedures

Although the six TAVR procedures have a 000-day global, the procedure is considered a major cardiac procedure where the patients will typically stay in the hospital for 3 – 6 days (per data from the STS/ACC TVT Registry). As with other major surgical procedures that have a 000-day global (include several ECMO codes (starting at CPT code 33951) and thoracoscopy codes (starting at CPT code 32601)), the multispecialty team care of the patient will vary significantly by patient and institution and the 000-day global allows for appropriate care from multiple specialties without overlap in physician work or payment. All six of the codes in this family typically require a same-day post-procedure critical care visit.

Same Day Post-Procedure Visit for CPT codes 33361-33366

The initial postoperative course following TAVR is similar to other postoperative cardiac surgery procedures involving a heart valve. Post-operative care involves monitoring of the patient's hemodynamic condition, including cardiac rhythm, rate and conduction abnormalities. Cardiac arrhythmias are assessed. Atrial extrasystoles, either isolated or in prolonged runs, are differentiated from ventricular extrasystoles or runs which are correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed as appropriate based on monitoring lines that are utilized for each patient. Filling pressures (central venous pressure, pulmonary artery diastolic pressure and left atrial ("wedge" pressure) are correlated at baseline and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

adverse end-organ effects. Peripheral perfusion, with special emphasis on end-organ perfusion, is carefully evaluated by observation and physical exam, correlating findings with invasive monitoring results. Any TAVR performed via a peripheral artery access (CPT codes 33361, 33362, 33363 and 33364) will necessitate a detailed assessment of distal arterial perfusion and vascular integrity of the artery. In addition, the vascular access wounds associated with CPT codes 33361, 33362, 33363 and 33364 will be assessed as part of standard wound care. The median sternotomy wound associated with CPT code 33365 will be evaluated for abnormal drainage, sternal instability, etc. Chest tubes placed prior to closure of the sternotomy wound will be assessed for excessive blood loss and air leaks. Post procedure chest x-ray is reviewed for post-operative pneumothorax. Similarly, the thoracotomy wound associated with CPT code 33366 is assessed for stability of the chest wall, abnormal drainage, etc. Chest tubes placed prior to closure of the thoracotomy wound are assessed for excessive blood loss and air leaks. Post procedure chest x-ray is reviewed for post-operative pneumothorax. The critical care visit covers the time that both physicians independently spend with the patient directly related to the procedure providing critical care services the same day after the procedure. The services provided do not overlap and are not duplicative with each physician managing and evaluating the patient from different post-operative perspectives.

33361 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach***
The RUC reviewed the survey results from 36 co-surgeon teams (one interventional cardiologist and one cardiac surgeon each) completing for their concurrent times. The custom survey instrument, which had been approved by the Research Subcommittee, specifically instructed the survey respondents to "estimate the time and work involved in performing these procedures as a team, not as two individuals working separately." The RUC recommends the following concurrent physician times: pre-service evaluation of 50 minutes, pre-service positioning of 15 minutes, pre-service scrub/dress/wait of 20 minutes, intra-service time of 90 minutes, 30 minutes of immediate post-service time and one 99291 post-operative critical care visit on the day of the procedure. The RUC referenced the median TVT intra-service time was 92 minutes, noting the similarity to the median survey time, although the survey had been completed more recently than date range sourced from the registry. For the immediate post-service time, the specialty societies are applying a reduction of 3 minutes from the standard package time for a total of 30 minutes as supported by the survey. The RUC agreed with the specialty that this was appropriate since this procedure includes a percutaneous approach, which does not require the same post procedure wound management necessary for the other procedures with open approaches.

The RUC reviewed the survey 25th percentile work RVU of 25.00 and agreed that this value somewhat overstates the amount of physician work involved. To determine an appropriate work RVU, the RUC, Research Subcommittee and presenting specialties exhaustively explored several potential methods spanning three RUC meetings (October 2017, January 2018 and April 2018) to come to an appropriate valuation and were unable to find an appropriate direct crosswalk to an individual code (including when the search was expanded to 010-day and 090-day services) due to a very limited number of comparable codes. To arrive at an appropriate valuation, the specialty societies proposed and the RUC agreed to add the time and value of a critical care visit to another 000-day code which describes a major cardiothoracic procedure. The RUC reviewed CPT codes 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU=17.97, intra-service time of 90 minutes, total time of 208 minutes) and 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, total time of 70 minutes), which aggregate to form a potential crosswalk value of 22.47 work RVUs and would represent a total time of 278 minutes. The RUC compared the survey code to the 93591/99291 pairing, and agreed that a value of 22.47 would also

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

be appropriate for the survey code. CPT code 93591 is also a 000-day major surgical procedure performed by interventional cardiology using a percutaneous approach and adding one critical care visit would bridge the gap between directly comparing these two services. Therefore, the RUC recommends a direct work RVU crosswalk from CPT code 33361 to the pairing of 93591 and 99291 (22.47 work RVUs). The RUC also reviewed CPT codes 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, intra-service time of 120 minutes and total time of 210) and 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, total time of 70 minutes), which also aggregate to form 22.47 work RVUs and would support a similar valuation for the survey code. When accounting for the application of the -62 co-surgeon modifier, the adjusted IWPUT for an individual physician would be 0.081 which is lower than the IWPUT of the key reference codes selected by the survey respondents. **The RUC recommends a work RVU of 22.47 for CPT code 33361.**

33362 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach***
The RUC reviewed the survey results from 35 co-surgeon teams (one interventional cardiologist and one cardiac surgeon each) completing for their concurrent times. The custom survey instrument, which had been approved by the Research Subcommittee, specifically instructed the survey respondents to "estimate the time and work involved in performing these procedures as a team, not as two individuals working separately." The RUC recommends the following concurrent physician times: pre-service evaluation of 50 minutes, pre-service positioning of 15 minutes, pre-service scrub/dress/wait of 20 minutes, intra-service time of 103 minutes, 45 minutes of immediate post-service time and one 99291 post-operative critical care visit on the day of the procedure. The RUC compared the median survey time of 90 minutes and the median TVT intra-service time was 103 minutes, and agreed that assigning identical intra-service times for CPT codes 33361 and 33362 (of 90 minutes) would create a rank-order anomaly since an open approach entails more time and work relative to a percutaneous approach. Therefore, for this service, the RUC agreed that using the median registry skin-to-skin time of 103 minutes would be more appropriate. The RUC agreed with the specialty that an immediate post-service time of 45 minutes is appropriate since this procedure includes an open approach, which requires additional post procedure wound management necessary relative to CPT code 33361, which involves a percutaneous approach.

The RUC reviewed the survey 25th percentile work RVU of 28.00 and agreed that this value somewhat overstates the amount of physician work involved. To determine an appropriate work RVU, the RUC, Research Subcommittee and presenting specialty societies exhaustively explored several potential methods spanning three RUC meetings (October 2017, January 2018 and April 2018) to come to an appropriate valuation and were unable to find an appropriate direct crosswalk to an individual code (including when the search was expanded to 010-day and 090-day services) due to a very limited number of comparable codes. To arrive at an appropriate valuation, the specialties proposed and the RUC agreed to add the time and value of a critical care visit and an open approach code to another 000-day code which describes a major cardiothoracic procedure. The RUC agreed that the same foundational crosswalk of CPT code 93591 should be used for all six TAVR codes to maintain appropriate relativity. In addition, as the addition of the approach code would only represent the work differential between performing an open approach of the femoral artery versus a percutaneous approach of the femoral artery, the RUC agreed that a 50 percent reduction should be applied to the proxy approach code, even though the 50 percent payment reduction does not apply to add-on codes (e.g. -51 modifier reduction). The RUC reviewed CPT codes 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU=17.97,

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

intra-service time of 90 minutes, total time of 208 minutes), one half of open femoral artery approach code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 2.07 (50% of 4.13), intra-service time of 20 minutes (50% of 40)) and 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, total time of 70 minutes) (17.97 + 2.07 + 4.50 = 24.54), which aggregate to form a potential crosswalk value of 24.54 work RVUs and would represent a total time of 298 minutes. The RUC compared the survey code to the 93591/99291/half of 34812 grouping, and agreed that a value of 24.54 would also be appropriate for the survey code. CPT code 93591 is also a 000-day major surgical procedure performed by interventional cardiology – including 50 percent of the value of the code describing an open approach of the femoral artery and adding one critical care visit would bridge the gap between directly comparing these two services. Therefore, the RUC recommends a direct work RVU crosswalk from CPT code 33361 to the grouping of 93591, one half of 34812 and 99291 (24.54 work RVUs). When accounting for the application of the -62 co-surgeon modifier, the adjusted IWPUT for an individual physician would be 0.080 which is lower than the IWPUT of the key reference codes selected by the survey respondents. **The RUC recommends a work RVU of 24.54 for CPT code 33362.**

33363 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach***
The RUC reviewed the survey results from 31 co-surgeon teams (one interventional cardiologist and one cardiac surgeon each) completing for their concurrent times. The custom survey instrument, which had been approved by the Research Subcommittee, specifically instructed the survey respondents to "estimate the time and work involved in performing these procedures as a team, not as two individuals working separately." The RUC recommends the following concurrent physician times: pre-service evaluation of 50 minutes, pre-service positioning of 15 minutes, pre-service scrub/dress/wait of 20 minutes, intra-service time of 100 minutes, 45 minutes of immediate post-service time and one 99291 post-operative critical care visit on the day of the procedure. The specialty societies noted that this rarely performed service did not have enough utilization in the TVT registry to reach the 95 percent confidence interval necessary for the time data to be considered representative; therefore, the intra-service time for this service was not referenced. The RUC agreed with the specialty that an immediate post-service time of 45 minutes is appropriate since this procedure includes an open approach, which requires additional post procedure wound management necessary relative to CPT code 33361 which involves a percutaneous approach.

The RUC reviewed the survey 25th percentile work RVU of 28.25 and agreed that this value somewhat overstates the amount of physician work involved. To determine an appropriate work RVU, the RUC, Research Subcommittee and presenting specialty societies exhaustively explored several potential methods spanning three RUC meetings (October 2017, January 2018 and April 2018) to come to an appropriate valuation and were unable to find an appropriate direct crosswalk to an individual code (including when the search was expanded to 010-day and 090-day services) due to a very limited number of comparable codes. To arrive at an appropriate valuation, the specialties proposed and the RUC agreed to add the time and value of a critical care visit and an open approach code to another 000-day code which describes a major cardiothoracic procedure. The RUC agreed that the same foundational crosswalk of CPT code 93591 should be used for all six TAVR codes to maintain appropriate relativity. In addition, as the addition of the approach code would only represent the work differential between performing using an open axillary artery approach versus a percutaneous approach of the femoral artery for CPT code 33361, the RUC agreed that a 50 percent

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

reduction should be applied to the proxy approach code, even though the 50 percent payment reduction does not apply to add-on codes (e.g. -51 modifier reduction). The RUC reviewed CPT codes 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU=17.97, intra-service time of 90 minutes, total time of 208 minutes), one half of open axillary artery approach code 34715 *Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 3.00 (50% of 6.00), intra-service time of 30 minutes (50% of 60)) and 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, total time of 70 minutes), (17.97 + 3.00 + 4.50 = 25.47), which aggregate to form a potential crosswalk value of 25.47 work RVUs and would represent a total time of 308 minutes. The RUC compared the survey code to the 93591/99291/half of 34715 grouping, and agreed that a value of 25.47 would also be appropriate for the survey code. CPT code 93591 is also a 000-day major surgical procedure performed by interventional cardiology – including 50 percent of the value of the code describing an open approach of the axillary artery and adding one critical care visit would bridge the gap between directly comparing these two services. Therefore, the RUC recommends a direct work RVU crosswalk from CPT code 33361 to the grouping of 93591, one half of 34715 and 99291 (25.47 work RVUs). When accounting for the application of the-62 co-surgeon modifier, the adjusted IWPUT for an individual physician would be 0.088 which is lower than the IWPUT of the key reference codes selected by the survey respondents. **The RUC recommends a work RVU of 25.47 for CPT code 33363.**

33364 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach***
The RUC reviewed the survey results from 28 co-surgeon teams (one interventional cardiologist and one cardiac surgeon each) completing for their concurrent times. CPT code 33364 did not reach 30 survey responses and will be re-reviewed in three years by the Relativity Assessment Workgroup. Specialty societies will submit an action plan indicating whether this service should either be resurveyed or referred to the CPT Editorial Panel for subsequent deletion or revision to a Category III code. The custom survey instrument, which had been approved by the Research Subcommittee, specifically instructed the survey respondents to "estimate the time and work involved in performing these procedures as a team, not as two individuals working separately." The RUC recommends the following concurrent physician times: pre-service evaluation of 50 minutes, pre-service positioning of 15 minutes, pre-service scrub/dress/wait of 20 minutes, intra-service time of 94 minutes, 45 minutes of immediate post-service time and one 99291 post-operative critical care visit on the day of the procedure. The specialty noted that this rarely performed service did not have enough utilization in the TVT registry to reach the 95 percent confidence interval necessary for the time data to be considered representative; therefore, the intra-service time for this service was not referenced. The RUC agreed with the specialty societies that an immediate post-service time of 45 minutes is appropriate since this procedure includes an open approach, which requires additional post procedure wound management necessary relative to CPT code 33361 which involves a percutaneous approach.

The RUC reviewed the survey 25th percentile work RVU of 28.75 and agreed that this value somewhat overstates the amount of physician work involved. To determine an appropriate work RVU, the RUC, Research Subcommittee and presenting specialties exhaustively explored several potential methods spanning three RUC meetings (October 2017, January 2018 and April 2018) to come to an appropriate valuation and were unable to find an appropriate direct crosswalk to an individual code (including when the search was expanded to 010-day and 090-day services) due to a very limited number of comparable codes. To arrive at an appropriate valuation, the specialties proposed and the RUC agreed to add the

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

time and value of a critical care visit and an open approach code to another 000-day code which describes a major cardiothoracic procedure. The RUC agreed that the same foundational crosswalk to CPT code 93591 should be used for all six TAVR codes to maintain appropriate relativity. In addition, as the addition of the approach code would only represent the work differential between performing using an open iliac artery approach versus a percutaneous approach of the femoral artery for CPT code 33361, the RUC agreed that a 50 percent reduction should be applied to the proxy approach code, even though the 50 percent payment reduction does not apply to add-on codes (e.g. -51 modifier reduction). The RUC reviewed CPT codes 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU=17.97, intra-service time of 90 minutes, total time of 208 minutes), one half of open iliac artery approach code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 3.50 (50% of 7.00), intra-service time of 30 minutes (50% of 60)) and 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, total time of 70 minutes) (17.97 + 3.50 + 4.50 = 25.97), which aggregate to form a potential crosswalk value of 25.97 work RVUs and would represent a total time of 308 minutes. The RUC compared the survey code to the 93591/99291/half of 34820 grouping, and agreed that a value of 25.97 would also be appropriate for the survey code. CPT code 93591 is also 000-day major surgical procedure performed by interventional cardiology – including 50 percent of the value of the code describing an open approach of the iliac artery and adding one critical care visit would bridge the gap between directly comparing these two services. Therefore, the RUC recommends a direct work RVU crosswalk from CPT code 33361 to the grouping of 93591, one half of 34820 and 99291 (25.97 work RVUs). When accounting for the application of the -62 co-surgeon modifier, the adjusted IWPUT for an individual physician would be 0.097 which is lower than the IWPUT of the key reference codes selected by the survey respondents. **The RUC recommends a work RVU of 25.97 for CPT code 33364.**

33365 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)***

The RUC reviewed the survey results from 31 co-surgeon teams (one interventional cardiologist and one cardiac surgeon each) completing for their concurrent times. The custom survey instrument, which had been approved by the Research Subcommittee, specifically instructed the survey respondents to "estimate the time and work involved in performing these procedures as a team, not as two individuals working separately." The RUC recommends the following concurrent physician times: pre-service evaluation of 50 minutes, pre-service positioning of 15 minutes, pre-service scrub/dress/wait of 20 minutes, intra-service time of 120 minutes, 45 minutes of immediate post-service time and one 99291 post-operative critical care visit on the day of the procedure. The specialty noted that this rarely performed service did not have enough utilization in the TVT registry to reach the 95 percent confidence interval necessary for the time data to be considered representative; therefore, the intra-service time for this service was not referenced. The RUC agreed with the specialty that an immediate post-service time of 45 minutes is appropriate since this procedure includes an open approach, which requires additional post procedure wound management necessary relative to CPT code 33361 which involves a percutaneous approach.

The RUC reviewed the survey 25th percentile work RVU of 34.00 and agreed that this value somewhat overstates the amount of physician work involved. To determine an appropriate work RVU, the RUC, Research Subcommittee and presenting specialties exhaustively explored several

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

potential methods spanning three RUC meetings (October 2017, January 2018 and April 2018) to come to an appropriate valuation and were unable to find an appropriate direct crosswalk to an individual code (including when the search was expanded to 010-day and 090-day services) due to a very limited number of comparable codes. To arrive at an appropriate valuation for the open approach TAVR services, the specialties proposed and the RUC agreed to add the time and value of a critical care visit and an open approach code to another 000-day code which describes a major cardiothoracic procedure. However, there is no transaortic approach code to use as a proxy for the valuation of CPT code 33365, so the RUC reviewed the existing value differential between CPT codes 33366 and 33365 of 2.76 work RVUs. The RUC deducted this amount from its recommended work RVU for code 33366 to arrive at a work RVU of 26.59 (29.35 minus 2.76). The RUC noted that this value would have appropriate rank order with its other recommended work RVUs. When accounting for the application of the -62 co-surgeon modifier, the adjusted IWPUT for an individual physician would be 0.079 which is lower than the IWPUT of the key reference codes selected by the survey respondents. **The RUC recommends a work RVU of 26.59 for CPT code 33365.**

33366 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)***
The RUC reviewed the survey results from 31 co-surgeon teams (one interventional cardiologist and one cardiac surgeon each) completing for their concurrent times. The custom survey instrument, which had been approved by the Research Subcommittee, specifically instructed the survey respondents to "estimate the time and work involved in performing these procedures as a team, not as two individuals working separately." The RUC recommends the following concurrent physician times: pre-service evaluation of 50 minutes, pre-service positioning of 15 minutes, pre-service scrub/dress/wait of 20 minutes, intra-service time of 120 minutes, 45 minutes of immediate post-service time and one 99291 post-operative critical care visit on the day of the procedure. The specialty noted that this rarely performed service did not have enough utilization in the TVT registry to reach the 95 percent confidence interval necessary for the time data to be considered representative; therefore, the intra-service time for this service was not referenced. The RUC agreed with the specialty that an immediate post-service time of 45 minutes is appropriate since this procedure includes an open approach, which requires additional post procedure wound management necessary relative to 33361 which involves a percutaneous approach.

The RUC reviewed the survey 25th percentile work RVU of 34.50 and agreed that this value somewhat overstates the amount of physician work involved. To determine an appropriate work RVU, the RUC, Research Subcommittee and presenting specialties exhaustively explored several potential methods spanning three RUC meetings (October 2017, January 2018 and April 2018) to come to an appropriate valuation and were unable to find an appropriate direct crosswalk to an individual code (including when the search was expanded to 010-day and 090-day services) due to a very limited number of comparable codes. In order to arrive at an appropriate valuation, the specialties proposed and the RUC agreed to add the time and value of a critical care visit and an open approach code to another 000-day code which describes a major cardiothoracic procedure. The RUC agreed that the same foundational crosswalk to CPT code 93591 should be used for all six TAVR codes to maintain appropriate relativity. The RUC reviewed CPT codes 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU=17.97, intra-service time of 90 minutes, total time of 208 minutes), one half of thoracotomy exposure code 32100 Thoracotomy; with exploration (work RVU= 6.88 (50% of 13.75 as -51 modifier would apply to this service)) and 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, total time of 70 minutes) (17.97

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

+ 6.88 + 4.50 = 29.35), which aggregate to form a potential crosswalk value of 29.35 work RVUs. The RUC compared the survey code to the 93591/99291/half of 32100 grouping, and agreed that a value of 29.35 would also be appropriate for the survey code. CPT code 93591 is also a 000-day major surgical procedure performed by interventional cardiology – including 50 percent of the value of the code describing a thoracotomy and adding one critical care visit would bridge the gap between directly comparing these two services. Therefore, the RUC recommends a direct work RVU crosswalk from CPT code 33366 to the grouping of CPT code 93591, one half of 34200 and 99291 (29.35 work RVUs). When accounting for the application of the -62 co-surgeon modifier, the adjusted IWPUT for an individual physician would be 0.093 which is lower than the IWPUT of the key reference codes selected by the survey respondents. **The RUC recommends a work RVU of 29.35 for CPT code 33366.**

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

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

New Technology
CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

RAW Flag for Service with Less than 30 Survey Responses
CPT code 33364 did not reach 30 survey responses and will be re-reviewed in three years by the Relativity Assessment Workgroup. Specialty societies will submit an action plan indicating whether this service should either be resurveyed or referred to the CPT Editorial Panel for subsequent deletion or revision to a Category III code.

Do Not Use to Validate for Physician Work
The RUC agreed that CPT codes 33361-33366 should continue to be labeled in the RUC database with a flag that they should not be used to validate physician work. These unique services which are required to be performed by co-surgeons were valued using an unconventional methodology which would not be appropriate to compare the relativity for other codes.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	000	22.47
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	000	24.54
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	000	25.47
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	000	25.97
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	000	26.59
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	000	29.35

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33361 Tracking Number Original Specialty Recommended RVU: **25.00**
Presented Recommended RVU: **22.47**
Global Period: 000 Current Work RVU: **25.13** RUC Recommended RVU: **22.47**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 81-year-old male presents with symptomatic aortic stenosis, hypertension, Class III-IV heart failure with an STS Risk Score of 7.5. The aortic stenosis is characterized as life-limiting with a documented aortic valve area of 0.6 cm2. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who recommends percutaneous transcatheter aortic valve replacement.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 6% , Overnight stay-more than 24 hours 94%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

Description of Pre-Service Work: The patient's history, records, and laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary angiogram, and transthoracic echocardiogram are reviewed and measurements are confirmed. This includes a review of the primary CT and angiographic images from clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is considered and if appropriate, initiated or continued. Additional pre-procedure functions include writing orders for adequate sedation and patient support and reviewing study arrangements and procedures with the technical, nursing, and other assisting personnel. Appropriate communication is conducted with the patient and the patient's family as well as with other medical professionals as needed. The procedure is reviewed with the patient and the patient's family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments, and supplies for the procedure are confirmed to be available and operational. The patient is positioned on the procedural table and attached to cardiac electrodes and an oxygen saturation monitor. Appropriate anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. Pre-procedural echocardiography is performed. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are present. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiographer, and echocardiography technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive. A surgical "time out" is performed during which confirmation of critical information is ensured, such as the patient's identity, the planned procedure, the access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances that might influence the procedure.

Description of Intra-Service Work: After establishing femoral venous access, a temporary transvenous pacemaker electrode is advanced into the apex of the right ventricle and tested for proper electrical capture. Arterial access (e.g., femoral, radial,

or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guidewire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. The contralateral iliac artery is wired and a catheter placed for angiography to access the vessel in the appropriate area. Femoral access is obtained and a sheath is placed. Two Perclose devices are deployed in a preclose fashion for later vessel closure. A long wire is placed then past the sheath from the contralateral catheter for vessel protection.

Using fluoroscopic guidance, a standard guidewire is advanced to the descending aorta and exchanged for a stiff guidewire with an angiographic catheter. Over the stiff guidewire, the arterial puncture site is progressively enlarged with dilators, and a large-bore vessel introducer sheath is inserted and advanced. The guidewire is removed and antithrombotic therapy is administered to achieve therapeutic anticoagulation levels.

Under fluoroscopic guidance, the native aortic valve is crossed using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the guidewire into the left ventricle. Over a guidewire, this catheter is exchanged for a pigtail and simultaneous aortic and left ventricular pressure is recorded. A stiff guidewire is then placed in the left ventricule. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained and require repositioning. A large balloon catheter is passed over the guidewire and positioned across the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma or perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus. (If performed, TEE is separately reported.) Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing. After confirming satisfactory position and function of the valve (with echocardiography and angiography), as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter, guidewire, and sheath are removed from the patient. The opening of the access artery is closed, using the previously placed percutaneous sutures. A post closure angiography is performed to ensure adequate hemostasis and distal perfusion. The access site is monitored for adequate hemostasis. A sterile dressing is applied to the entry site.

Description of Post-Service Work: The physicians confirm the patient's hemodynamic status, including systemic arterial pressure, pulmonary artery pressure, and the patient's heart rhythm prior to removing the patient from the operating room and committing the patient to transfer to the intensive care unit. A focused vascular examination of the at-risk extremities is performed to assess for adequate limb perfusion. The patient is also assessed for possible early embolic complications such as stroke requiring a detailed neurologic examination as well as a focused physical examination for possible intra-abdominal catastrophe such as mesenteric ischemia. Postoperative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, and revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the postoperative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory transcathether aortic valve replacement therapy (TAVR) registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Richard Wright, MD; James Levett, MD; Stephen Lahey, MD; Marie-France Poulin, MD; Thad Waites, MD;				
Specialty(s):	ACC, STS, SCAI, AATS				
CPT Code:	33361				
Sample Size:	2535	**Resp N:**	36	**Response:** 1.4 %	
Description of Sample:	1000 interventional cardiologists, 1535 cardiac surgeons				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	38.00	**69.00**	120.00	300.00
Survey RVW:	13.50	25.00	**27.00**	32.75	48.00
Pre-Service Evaluation Time:			**63.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	30.00	60.00	**90.00**	120.00	140.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33361	**Recommended Physician Work RVU: 22.47**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	70.00	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33477	000	25.00	**RUC Time**

CPT Descriptor Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33976	000	30.75	**RUC Time**

CPT Descriptor Insertion of ventricular assist device; extracorporeal, biventricular

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	10,168

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 23 **% of respondents:** 63.8 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 11.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 33361	Top Key Reference CPT Code: 33477	2nd Key Reference CPT Code: **33976**
Median Pre-Service Time	85.00	63.00	95.00
Median Intra-Service Time	90.00	180.00	240.00
Median Immediate Post-service Time	30.00	33.00	120.00
Median Critical Care Time	70.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**275.00**	**276.00**	**455.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	39%	48%	13%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	48%	52%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	43%	49%
Physical effort required	4%	48%	48%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	35%	57%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	25%	75%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	25%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	75%	25%
Physical effort required	0%	25%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	0%	100%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

This family of codes was identified for review by the RAW New Technology Screen. Utilization has grown appropriately for these services as the technology and procedure diffused.

An Expert Panel with representatives from the American College of Cardiology (ACC), Society of Thoracic Surgeons (STS), American Association for Thoracic Surgery (AATS) and the Society for Cardiac Angiography and Interventions (SCAI) was convened to review the RUC survey results and TVT Registry data and finalize the recommendations.

SUMMARY

RUC SURVEY METHODOLOGY

At the April 2017 RUC meeting, the Research Subcommittee reviewed and the RUC approved use of a modified survey methodology using the current survey instrument with modifications similar to the 2012 TAVR survey allowing for the survey to be completed jointly by the co-operators who provide these services at their institutions. The Surveys were sent to 2,535 physicians (1535 STS members who self-identify as adult cardiac surgeons and 1000 interventional cardiologist). A Research Subcommittee reviewed and approved RSL was used for the survey and has been submitted as an exhibit.

STS/ACC TVT REGISTRY™

The TVT-R collects data on all US patients which have had TAVR resulting in 100% participation in the database. The TVT-R was queried for aggregate data since the Registry's inception (Q3 2013-Q3 2016) as well as for each individual year from Q3 – Q3 for 2014, 2105 and 2016. The data set included 50,991 patients for 3 years (2013 – 2016) and 32,146 patients for 2016 for codes 33361 and 33362. Data extraction included only those records that could be unequivocally and exclusively matched to CPT code 33361 or 33362. Patients were excluded if other procedures were performed simultaneously.

At the April 2017 RUC meeting, the RUC Research Subcommittee reviewed and the RUC approved the STS/ACC TVT Registry™ (TVT-R) as a database that meets the RUC's extant database criteria. The RUC also approved use of the *STS/CTS Alternate Five Year Review Methodology* that was used in the 2005 5-year review using a direct intensity survey which included a Research Subcommittee reviewed and approved RSL. This methodology relies on the intraservice mean time to derive a recommended work RVU through an intensity survey and reverse building block calculation. Per the established criterion, the TVT-R data was evaluated by the TVT-R staff for each individual code to determine if the data met the 95th/5% criterion (95th percentile confidence interval with a +-5% variability). There are two codes in the TVT-R that currently meet the 95th/5% criterion, which are 33361 (percutaneous femoral TAVR) and 33362 (open femoral TAVR).

After developing recommendations for 33361 and 33362 based on this alternate methodology for the October 2017 RUC meeting and raising concerns about the relativity of codes for which the application of cosurgery modifier 62 is required by CPT instruction and CMS Coverage Policy, the societies sought, and the RUC granted, a delay to regroup with the Research Subcommittee. At the January 2018 RUC meeting, societies and the Subcommittee discussed mechanisms for valuing these unique codes and confirmed that both the mean and median database intraservice time would be provided despite that fact that the mean has been identified as the central tendency of this data set, making the median an invalid measurement for this exercise. A key result of this discussion that is helpful to remember is that the RUC standard for extant data no longer allows that data to be used in the reverse building block formula that STS used for prior valuations; extant data can only be an additional data point for recommendations developed by RUC survey. As such, our recommendations are based on RUC survey data.

RATIONALE

DATA PROVIDED

The specialty societies have provided the following data for consideration by the RUC:

- RUC Summary Spreadsheet which contains survey data for each code, the median and mean intraservice times from the TVT-R data for codes 33361 and 33362 that met the 95th/5% criterion, the recommended inputs for each code, a line that shows the impact of modifier 62 (125% work RVU, 200% times), and two lines showing similar information for the RUC's 2012 recommendations that CMS later reduced.
- SORs for each code
- TAVR Databook for 33361 and 33362
- PE Summary Spreadsheet
- PE SOR

JOINT OPERATORS FOR THE PROCEDURES

There are six codes that represent the various approaches and insertion of the transcatheter aortic valve replacement (TAVR) procedures. Each of the six insertion codes were surveyed jointly by the cardiologist and the cardiac surgeon that jointly perform TAVR procedures at their institutions. For the TAVR insertion procedures there are always two physicians (a cardiologist and a cardiac surgeon) that participate in the case and both physicians utilize their specialty specific expertise and collaborate for the entire procedure. This aligns with the CPT language that requires modifier 62 for these codes.

> *Codes 33361, 33362, 33363, 33364, 33365, 33366 are used to report transcatheter aortic valve replacement (TAVR)/transcatheter aortic valve implantation (TAVI). TAVR/TAVI requires two physician operators and all components of the procedure are reported using modifier 62. (CPT 2018, page 210)*

In addition, all TAVR Services must be reported to the TVT-R. Medicare's National Coverage Decision, and the joint statements of the societies mandate the performance of these procedures by two physicians. The relevant section of the NCD is as follows:

The heart team's interventional cardiologist(s) and cardiac surgeon(s) must jointly participate in the intra-operative technical aspects of TAVR.

By CPT instruction and Medicare coverage, modifier 62 **is required** for all six codes (33361 – 33366) and results in each physician being allocated 62.5% of the physician work (and therefore total physician payment) described in the codes.

This joint operator paradigm aligns with the heart team approach used for these procedures. Both physicians do, in fact, execute each service aspect completely and independently. Both evaluate the patient independently before the procedure, obtain consent from the patient, are present and participate in the positioning of the patient, are scrubbed, present and actively participate in the procedure for the entire intra-operative period through the immediate post service time, and visit the patient separately, providing critical care services respective to their aspect of the surgical care after the procedure the same day.

COMPELLING EVIDENCE

The societies believe compelling evidence exists that the current values inappropriately value the physician work for this family. The current values—and a few of the preservice times—were assigned by CMS during rulemaking. The work RVUs for each code in the family were lowered by CMS from the 2012 survey median work RVU to the 25th-percentile work RVU. The RUC's 2012 recommendations are included in the summary spreadsheet and labeled "2012 REC."

The joint surveys performed in 2012 were of a targeted list of operators at sites that participated in the pivotal clinical trial of the first approved valve. Since then, additional manufactures have entered the marketplace. Subsequent generations of devices have been approved; smaller iterations of the device represent a change in technology. The technology diffused from dozens of trial sites to roughly 500 sites across the country. By deflating the work RVUs for this new, life-saving therapy in the initial years of TAVR's introduction, CMS pre-empted the ability of societies to identify future savings. The specialties argue that the RUC recommended values from 2012 are the appropriate values to use to compare the current recommendations independent of the CMS decision because the values were based on the same survey process and the same decision-making process for both survey periods.

This presentation is based on random surveys of interventional cardiologists and cardiac surgeons after five years of diffusion. It accurately represents the current state in terms of physician work. For these reasons, we request the RUC agree compelling evidence exists that the current values are inappropriate.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient for all six TAVR procedure codes.

ADDITIONAL EVALUATION TIME

For the evaluation, the Expert Panel is recommending an increase of 10 minutes over the package for a total evaluation time of 50 minutes for all codes in the family. This is supported by the survey data for each code. The expert panel feels that work associated with the evaluation for this family of services is the same regardless of the final approach used to accomplish the procedure and recommend that the preservice evaluation time be standardized throughout the family for consistency. We attribute some of the variability in the pre-service times in the survey to the fact that the same individuals did not necessarily respond to all six codes, as well as the survey response near the 30-response minimum. The total evaluation time accounts for the combined review of the patient by the physicians and the collaborative efforts that go into each case. The additional evaluation time accounts for the time each physician would spend separately with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure from their specialty specific aspect. Risks of the procedure, including alternatives such as cardiopulmonary bypass, alternative valve replacement technique, or discontinuation of the procedure would be discussed during the consent conversation. In preparation for the procedure, each physician will independently review the patient's laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram and primary CT and angiographic images from prior studies. The physicians determine appropriate antiplatelet and other pharmacologic therapy. The physician's must also coordiante with each other prior to the procedure to determine the final operative stratagey for the procedure. The Expert Panel felt that adding additional evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians as discussed above.

Code	Descriptor	pre-time pkg	pre-eval time Cur	pre-eval time Rec	global
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	4	45 mins	50 mins	000
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	4	45 mins	50 mins	000
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	4	45 mins	50 mins	000
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	4	45 mins	50 mins	000
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	4	50 mins	50 mins	000
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	4	50 mins	50 mins	000

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case for a total of 15 minutes. This is the current positioning time for these codes and the time is also supported by the survey data. The codes represent hybrid procedures each with the possibility of emergency cardiopulmonary bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency of the procedures. In addition, the patient must be positioned for all the approaches plus the induction of cardiopulmonary bypass for each of the cardiopulmonary bypass procedures.

Code	Descriptor	pre-time pkg	Posit time Cur	Posit time Rec	global
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	4	15 mins	15 mins	000
33362	Transcatheter aortic valve replacement	4	15 mins	15 mins	000

	(TAVR/TAVI) with prosthetic valve; open femoral artery approach				
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	4	15 mins	15 mins	000
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	4	15 mins	15 mins	000
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	4	15 mins	15 mins	000
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	4	15 mins	15 mins	000

SAME DAY IMMEDIATE POST TIME

Post service time package 9B General Anesthesia/Complex Patient was selected for all six codes. For code 33361 the survey supported 30 minutes of immediate post time and for codes 33362, 33364, 33365 and 33366 the survey supported 45 minutes of immediate post time. We also applied the current time of 45 minutes to code 33363 which is consistent with the codes deeper in the family and missed being the median by one response when responses were arrayed to identify the median. For the codes where the survey supported 45 minutes of post-time, which is the current amount of time associated with the codes, the specialties are requesting an increase of 12 minutes over the package time for a total time of 45 minutes, which is the current post time for the procedures. There are numerous examples in the RUC database supporting this time. For code 33361, the specialties are applying a reduction of 3 minutes from the package time for a total of 30 minutes as supported by the survey. The specialties felt that this was appropriate for this procedure since it includes a percutaneous approach, which does not require the same post procedure wound management necessary for the other procedures with open approaches.

Code	**Descriptor**	**Post-time pkg**	**Post time Cur**	**Post time Rec**	**global**
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	9B	45 mins	30 mins	000
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	9B	45 mins	45 mins	000
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	9B	45 mins	45 mins	000
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	9B	45 mins	45 mins	000
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	9B	45 mins	45 mins	000
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	9B	45 mins	45 mins	000

SAME DAY POST PROCEDURE VISIT

Although the six TAVR procedures have a 000-day global, the procedure is considered a major cardiac procedure where the patients will typically stay in the hospital for 3 – 6 days (TVT-R). As with other major surgical procedures that have a 000-day global (e.g. ECMO), the multispecialty team care of the patient will vary significantly by patient and

institution and the 000-day global allows for appropriate care from multiple specialties without overlap in work or reimbursement. The survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery was typical. That is consistent with the current valuation as well. The survey respondents indicated that a same-day critical care hospital visit is typical. The initial postoperative course following TAVR is similar to other postoperative cardiac surgery procedures involving a heart valve. Post-op care involves monitoring of the patient's hemodynamic condition, including cardiac rhythm, rate and conduction abnormalities. Cardiac arrhythmias are assessed. Atrial extrasystoles, either isolated or in prolonged runs are differentiated from ventricular extrasystoles or runs which are correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed as appropriate based on monitoring lines that are utilized for each patient. Filling pressures (central venous pressure, pulmonary artery diastolic pressure and left atrial ("wedge" pressure) are correlated at baseline and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion, with special emphasis on end-organ perfusion, is carefully evaluated by observation and physical exam, correlating findings with invasive monitoring results. Any TAVR performed via a peripheral artery access (33361,33362,33363,33364) will necessitate a detailed assessment of distal arterial perfusion and vascular integrity of the artery. In addition, the vascular access wounds associated with 33361,33362,33363,33364 will be assessed as part of standard wound care. The median sternotomy wound associated with 33365 will be evaluated for abnormal drainage, sternal instability, etc. Chest tubes placed prior to closure of the sternotomy wound will be assessed for excessive blood loss and air leaks. Post procedure chest x-ray is reviewed for post-operative pneumothorax. Similarly, the thoracotomy wound associated with 33366 is assessed for stability of the chest wall, abnormal drainage, etc. Chest tubes placed prior to closure of the thoracotomy wound are assessed for excessive blood loss and air leaks. Post procedure chest x-ray is reviewed for post-operative pneumothorax. The critical care visit covers the time that both physicians independently spend with the patient directly related to the procedure providing critical care services the same day after the procedure. The services provided do not overlap and are not duplicative with each physician managing and evaluating the patient from different post-operative perspectives. The survey supported a single critical care visit and the Expert Panel agreed. Other 000 codes with same-day visits include several ECMO codes (starting at 33951) and thoracoscopy codes (starting at 32601).

Code	Descriptor	Same Day PO Visit	Current code	Rec Code	global
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Yes	99291	99291	000
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Yes	99291	99291	000
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Yes	99291	99291	000
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Yes	99291	99291	000
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Yes	99291	99291	000
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Yes	99291	99291	000

33361

Code 33361 in this family is percutaneous transcatheter placement of a prosthetic aortic valve. The expert panel **recommends the survey 25th-percentile value of 25.00 work RVUs for 33361, with 50 minutes preservice time as discussed above, 90 minutes intraservice time from the survey median, 30 minutes postservice time as discussed above, and one same-day 99291.** This represents a decrease in time and RVU from the RUC's 2012 recommendations. The decrease in time is driven by the ability to more quickly manipulate a smaller, 3rd generation prosthetic valve through the vasculature to the heart; once that step has been completed, the work to correctly position and deploy the valve is unchanged and remains highly intense.

In addition to reliance on a random survey of providers familiar with this diffused technology, the societies suggest two supporting rationales the RUC could use to validate this recommendation. The first is a building block and magnitude estimation exercise. Second, although the RUC has indicated that they won't correct for the payment policy impact of modifier 62, the recommendations do not correlate to the fee schedule without some consideration of the joint survey and the requirement for joint operators for the procedures. As such, the second method begs the RUC's indulgence to consider the payment policy impact of modifier 62.

For the first, a supporting rationale would be similar to the one the RUC used when it first valued this code in 2012. Percutaneous ASD closure code 93580 has a work RVU of 17.97, intraservice time of 120, and total time of 210 with an IWPUT of 0.133. The addition of 4.50 RVUs from the performance of 99291 brings that number to 22.47. The difference between the work RVU recommendation based on the survey 25th-percentile of 25.00 and this building block calculation can be appropriately explained by the increased intensity of TAVR by magnitude estimation.

For the second, consider that the impact of the mandatory 62 modifier is 125% of this recommended RVU and 200% of the recommended times. That calculation is included in the summary spreadsheet and labeled "REC MOD 62 Impact." A code with a work RVU of 31.25, intra time of 180 minutes and total time of 550 minutes begins to look like a 90-day global code. Comparisons could be made between the 62-modifier value and times to transcatheter mitral valve repair code 33418. It has an identical intraservice time, slightly higher total time, slightly higher work RVU of 32.25, and an appropriately higher IWPUT. Similar comparisons could also be made to surgical AVR code 33405 that is longer in all time components, has a higher value, but still comes out with an IWPUT within 10% of 33361.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33361

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty interventional cardiology How often? Sometimes

Specialty cardiothoracic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 45000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. These patients are almost universally Medicare age. With roughly a third of Medicare beneficiaries in MA plans, the 45,000 in this estimate adds 50% to our FFS estimate below.

Specialty interventional cardiology Frequency 22500 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 22500 Percentage 50.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Utilization has grown since the first devices came to market in 2011. 2017 utilization could approach the level of prior peaks of surgical AVR, over 30,000. The specialties estimate utilization split evenly as services must be billed using cosurgery modifier 62.

Specialty interventional cardiology Frequency 15000 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 15000 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33361

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33362 Tracking Number Original Specialty Recommended RVU: **28.00**
Presented Recommended RVU: **24.54**
Global Period: 000 Current Work RVU: **27.52** RUC Recommended RVU: **24.54**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 81-year-old male presents with symptomatic aortic stenosis, hypertension, Class III-IV heart failure and an STS Risk score of 8.0. The aortic stenosis is characterized as life-limiting with a documented aortic valve area of 0.6 cm2. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who recommend percutaneous transcatheter aortic valve replacement. The femoral vessels are unsuitable for percutaneous cannulation. An open femoral approach is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 6% , Overnight stay-more than 24 hours 94%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 54%

Description of Pre-Service Work: The patient's history, records, and laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary angiogram, and transthoracic echocardiogram are reviewed and measurements are confirmed. This includes a review of the primary CT and angiographic images from prior studies. A physical examination is conducted. A clinical note is generated that summarizes the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is considered and if appropriate, initiated or continued. Additional pre-procedure functions include writing orders for adequate sedation and patient support and reviewing study arrangements and procedures with the technical, nursing, and other assisting personnel. Appropriate communication is conducted with the patient and the patient's family as well as with other medical professionals as needed. The procedure is reviewed with the patient and the patient's family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments, and supplies for the procedure are confirmed to be available and operational The patient is positioned on the procedural table and attached to cardiac electrodes and an oxygen saturation monitor. Appropriate anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. Pre-procedural echocardiography is performed. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are present. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiographer, and echocardiography technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive. A surgical "time Out" is performed during which confirmation of critical information is ensured, such as the patient's identity, the planned procedure, the access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances that might influence the procedure.

Description of Intra-Service Work: After establishing femoral venous access, a temporary transvenous pacemaker electrode is advanced into the apex of the right ventricle and tested for proper electrical capture. Arterial access (e.g., femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guidewire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. A skin incision is made in the inguinal region. The subcutaneous tissue is dissected until the common femoral artery is isolated. Care is taken to avoid injury to the femoral nerve and vein that lie in close proximity. The common, superficial, and deep femoral arteries are dissected and captured in vessel loops. The distal external iliac artery is typically included in the dissection. This approach facilitates introduction of the very large diameter sheath required for delivery of the transcatheter aortic valve especially in diseased arteries. It also serves to apply countertraction and temporarily reduce tortuosity of the iliac arteries as the sheath is advanced. The anterior surface of the common femoral or distal-most external iliac artery is accessed. If necessary, an end-side prosthetic graft is sewn in place to facilitate catheter delivery and/or preserve distal leg perfusion. Antithrombotic therapy (weight-based dose of heparin) is begun. Using fluoroscopic guidance, a standard guidewire is advanced to the descending aorta and exchanged for a stiff guidewire with an angiographic catheter. Over the stiff guidewire, a large-bore vessel introducer sheath is inserted and advanced to a level that is inferior to the renal arteries.

Under fluoroscopic guidance, the native aortic valve is crossed using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle, and the guidewire is exchanged for a stiff guidewire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained and require repositioning. A large balloon catheter is passed over the guidewire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus. (If performed, TEE is separately reported.) Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter, guidewire, and sheath are removed from the patient. The femoral arteriotomy is repaired with sutures. Hemostasis is achieved, the wound is irrigated, and the soft tissue is reapproximated in several layers. Skin closure is performed with staples or sutures. A sterile dressing is applied to the entry site.

Description of Post-Service Work: The physicians confirm the patient's hemodynamic status, including systemic arterial pressure, pulmonary artery pressure, and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to transfer to the intensive care unit. A focused vascular examination of the at-risk extremities is performed to assess for adequate limb perfusion. The patient is also assessed for possible early embolic complications such as stroke requiring a detailed neurologic examination as well as a focused physical examination for possible intra-abdominal catastrophe such as mesenteric ischemia. Postoperative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, and revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post-operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory transcathether aortic valve replacement therapy (TAVR) registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Richard Wright, MD; James Levett, MD; Stephen Lahey, MD; Marie-France Poulin, MD; Thad Waites, MD;				
Specialty(s):	ACC, STS, SCAI, AATS				
CPT Code:	33362				
Sample Size:	2535	**Resp N:**	35	**Response:** 1.3 %	
Description of Sample:	1000 interventional cardiologists, 1535 cardiac surgeons				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	15.00	140.00
Survey RVW:	13.75	28.00	**31.00**	35.00	53.55
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	45.00	80.00	**90.00**	120.00	150.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33362	**Recommended Physician Work RVU: 24.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**103.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	70.00	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33976	000	30.75	**RUC Time**

CPT Descriptor Insertion of ventricular assist device; extracorporeal, biventricular

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33477	000	25.00	**RUC Time**

CPT Descriptor Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	10,168

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 42.8 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 25.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 33362	Top Key Reference CPT Code: 33976	2nd Key Reference CPT Code: **33477**
Median Pre-Service Time	85.00	95.00	63.00
Median Intra-Service Time	103.00	240.00	180.00
Median Immediate Post-service Time	45.00	120.00	33.00
Median Critical Care Time	70.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**303.00**	**455.00**	**276.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	43%	21%	36%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	29%	64%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	43%	57%
Physical effort required	0%	29%	71%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	21%	72%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	22%	33%	44%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	44%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	44%	56%
Physical effort required	11%	56%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	56%	44%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Code 33362 describes the open femoral approach for transcatheter placement of an aortic valve replacement prosthesis. As previously described, surveys were sent to 2,535 physicians (1535 STS members who self-identify as adult cardiac surgeons and 1000 interventional cardiologist). An Expert Panel with representatives from the American College of Cardiology (ACC), Society of Thoracic Surgeons (STS), American Association for Thoracic Surgery (AATS) and the Society

for Cardiac Angiography and Interventions (SCAI) was convened to review the RUC survey results and TVT Registry data and finalize the recommendations.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient.

ADDITIONAL EVALUATION TIME

For the evaluation, the Expert Panel is recommending an increase of 10 minutes over the package for a total evaluation time of 50 minutes for all codes in the family. This is supported by the survey data. Risks of the procedure, including alternatives such as cardiopulmonary bypass, alternative valve replacement technique, or discontinuation of the procedure would be discussed during the consent conversation. In preparation for the procedure, each physician will independently review the patient's laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram and primary CT and angiographic images from prior studies. The physicians determine appropriate antiplatelet and other pharmacologic therapy. The physician's must also coordiante with each other prior to the procedure to determine the final operative stratagey for the procedure. The Expert Panel felt that adding additional evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians as discussed above.

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case for a total of 15 minutes. This is the current positioning time for these codes and the time is also supported by the survey data. The codes represent hybrid procedures each with the possibility of emergency cardiopulmonary bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency of the procedures. In addition, the patient must be positioned for all the approaches plus the induction of cardiopulmonary bypass for each of the cardiopulmonary bypass procedures.

SAME DAY IMMEDIATE POST TIME

Post service time package 9B General Anesthesia/Complex Patient was selected for all six codes. The 33362 survey supported 45 minutes of immediate post time. The specialties are recommending an increase of 12 minutes over the package time for a total time of 45 minutes, which is the current post time for the procedure. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

Although 33362 is a 000-day global, the procedure is considered a major cardiac procedure where the patients will typically stay in the hospital for 4 – 6 days (TVT-R). As with other major surgical procedures that have a 000-day global (e.g. ECMO), the multispecialty team care of the patient will vary significantly by patient and institution and the 000-day global allows for appropriate care from multiple specialties without overlap in work or reimbursement. The survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery was typical. That is consistent with the current valuation as well. The survey respondents indicated that a same-day critical care hospital visit is typical. The initial postoperative course following TAVR is similar to other postoperative cardiac surgery procedures involving a heart valve. Post-op care involves monitoring of the patient's hemodynamic condition, including cardiac rhythm, rate and conduction abnormalities. Cardiac arrhythmias are assessed. Atrial extrasystoles, either isolated or in prolonged runs are differentiated from ventricular extrasystoles or runs which are correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed as appropriate based on monitoring lines that are utilized for each patient. Filling pressures (central venous pressure, pulmonary artery diastolic pressure and left atrial ("wedge" pressure) are correlated at baseline and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion, with special emphasis on end-organ perfusion, is carefully

evaluated by observation and physical exam, correlating findings with invasive monitoring results. Any TAVR performed via a peripheral artery access necessitates a detailed assessment of distal arterial perfusion and vascular integrity of the artery. In addition, the vascular access wounds will be assessed as part of standard wound care. The critical care visit covers the time that both physicians independently spend with the patient directly related to the procedure providing critical care services the same day after the procedure. The services provided do not overlap and are not duplicative with each physician managing and evaluating the patient from different post-operative perspectives. The survey supported a single critical care visit and the Expert Panel agreed. Other 000 codes with same-day visits include several ECMO codes (starting at 33951) and thoracoscopy codes (starting at 32601).

33362

Code 33362 in this family is open femoral transcatheter placement of a prosthetic aortic valve. The expert panel **recommends the survey 25th-percentile value of 28.00 work RVUs for 33362, with 50 minutes preservice time, 90 minutes intraservice time from the survey median, 45 minutes postservice time, and one same-day 99291.** This represents a decrease in time and RVU from the RUC's 2012 recommendations. We note that the mean database times for this service were 27 minutes longer than survey respondents indicated which would support a higher value than 33361. This increase also does a fair job of incorporating some value for the open femoral access, in comparison to code 34812 for open femoral artery exposure with a work RVU of 4.13 and time of 40 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33362

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty interventional cardiology How often? Sometimes

Specialty cardiothoracic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4650
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. These patients are almost universally Medicare age. With roughly a third of Medicare beneficiaries in MA plans, the 4650 in this estimate adds 50% to our FFS estimate below.

Specialty interventional cardiology Frequency 2325 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 2325 Percentage 50.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. FFS utilization grew then declined last year. This estimate is similar to 2016 utilization. Specialty estimates split utilization evenly as services must be billed using cosurgery modifier 62.

Specialty interventional cardiology Frequency 1550 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 1550 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33362

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33363 Tracking Number Original Specialty Recommended RVU: **28.25**
Presented Recommended RVU: **25.47**
Global Period: 000 Current Work RVU: **28.50** RUC Recommended RVU: **25.47**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 77-year-old male presents with symptomatic aortic stenosis, hypertension, peripheral artery disease, Class III-IV heart failure and an STS Risk score of 7.6. The aortic stenosis is life-limiting with a documented aortic valve orifice area of 0.6 cm2. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who recommend percutaneous transcatheter aortic valve replacement. Severe aortoiliac occlusive disease precludes both a percutaneous and/or open femoral or iliac arterial approach for prosthesis delivery. A direct, open surgical approach to the axillary artery for TAVR prosthesis delivery is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 61%

Description of Pre-Service Work: The patient's history, records, and laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary angiogram, and transthoracic echocardiogram are reviewed and measurements are confirmed. This includes a review of the primary CT and angiographic images from prior studies. A physical examination is conducted. A clinical note is generated that summarizes the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is considered and if appropriate, initiated or continued. Additional pre-procedure functions include writing orders for adequate sedation and patient support and reviewing study arrangements and procedures with the technical, nursing, and other assisting personnel. Appropriate communication is conducted with the patient and the patient's family as well as with other medical professionals as needed. The procedure is reviewed with the patient and the patient's family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments, and supplies for the procedure are confirmed to be available and operational. The patient is positioned on the procedural table and attached to cardiac electrodes and an oxygen saturation monitor. Appropriate anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. Pre-procedural echocardiography is performed. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are present. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiographer, and echocardiography technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive. A surgical "Time out" is performed during which confirmation of critical information is ensured, such as the patient's identity, the planned procedure, the access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances that might influence the procedure.

Description of Intra-Service Work: After establishing femoral venous access, a temporary transvenous pacemaker electrode is advanced into the apex of the right ventricle and tested for proper electrical capture. Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guidewire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve. A subclavicular incision is made, and the subcutaneous tissue is dissected until the axillary artery is located. Care is taken to avoid injury to the brachial plexus and axillary vein that lie in close proximity. Once the axillary artery is adequately exposed , proximal and distal control, relative to the intended vessel entry point, is secured with vessel loops. Intravenous antithrombotic therapy is begun. Proximal and distal vascular clamps are applied. A longitudinal arteriotomy is made. If necessary, a graft conduit (a large diameter tubular segment of synthetic bypass graft) is brought into the field, tailored to appropriate size, and an end-to-side anastomosis of conduit to the axillary artery is performed with a running polypropylene suture. The conduit is clamped and vascular clamps are removed. The suture line is checked for hemostasis and additional sutures are applied as required. A guidewire is advanced into the conduit and then, subsequently, into the ascending aorta. A small sheath is placed over the guidewire.

Under fluoroscopic guidance, the native aortic valve is crossed using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle, and the wire is exchanged for a stiff guidewire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained and require repositioning. At that time, the small sheath in the axillary artery is removed over the wire and the axillary artery is serially dilated to accommodate the large-bore sheath. This is done over the stiff guidewire positioned in the left ventricule, under continuous fluoroscopic imaging to avoid wire movement. The large-bore sheath is advanced into the ascending aorta under fluoroscopic guidance. A large balloon catheter is passed over the guidewire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus. (If performed, TEE is separately reported.) Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter, guidewire, and sheath are removed from the patient. The axillary artery is then repaired with sutures. Hemostasis is achieved and protamine is given for reversal. The wound is irrigated and closed in layers. A sterile dressing is applied to the entry site.

Description of Post-Service Work: The physicians confirm the patient's hemodynamic status, including systemic arterial pressure, pulmonary artery pressure, and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to transfer to the intensive care unit. A focused vascular examination of the at-risk extremities is performed to assess for adequate limb perfusion. The patient is also assessed for possible early embolic complications such as stroke requiring a detailed neurologic examination as well as a focused physical examination for possible intra-abdominal catastrophe such as mesenteric ischemia. Postoperative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, and revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the postoperative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory transcathether aortic valve replacement therapy (TAVR) registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018		
Presenter(s):	Richard Wright, MD; James Levett, MD; Stephen Lahey, MD; Marie-France Poulin, MD; Thad Waites, MD;		
Specialty(s):	ACC, STS, SCAI, AATS		
CPT Code:	33363		
Sample Size:	2535	**Resp N:** 31	**Response:** 1.2 %
Description of Sample:	1000 interventional cardiologists, 1535 cardiac surgeons		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	5.00	50.00
Survey RVW:	14.00	28.25	**32.00**	36.50	55.55
Pre-Service Evaluation Time:			**62.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	50.00	90.00	**100.00**	120.00	180.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33363	**Recommended Physician Work RVU: 25.47**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**100.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	70.00	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33976	000	30.75	**RUC Time**

CPT Descriptor Insertion of ventricular assist device; extracorporeal, biventricular

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33477	000	25.00	**RUC Time**

CPT Descriptor Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	10,168

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 35.4 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 22.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 33363	Top Key Reference CPT Code: 33976	2nd Key Reference CPT Code: **33477**
Median Pre-Service Time	85.00	95.00	63.00
Median Intra-Service Time	100.00	240.00	180.00
Median Immediate Post-service Time	45.00	120.00	33.00
Median Critical Care Time	70.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**300.00**	**455.00**	**276.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	45%	9%	45%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	45%	55%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	36%	64%
Physical effort required	0%	27%	73%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	36%	64%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	14%	72%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	43%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	14%	86%
Physical effort required	14%	43%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	57%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Code 33363 describes the open axillary approach for transcatheter placement of an aortic valve replacement prosthesis. As previously described, surveys were sent to 2,535 physicians (1535 STS members who self-identify as adult cardiac surgeons and 1000 interventional cardiologist). An Expert Panel with representatives from the American College of Cardiology (ACC), Society of Thoracic Surgeons (STS), American Association for Thoracic Surgery (AATS) and the Society

for Cardiac Angiography and Interventions (SCAI) was convened to review the RUC survey results and TVT Registry data and finalize the recommendations.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient.

ADDITIONAL EVALUATION TIME

For the evaluation, the Expert Panel is recommending an increase of 10 minutes over the package for a total evaluation time of 50 minutes for all codes in the family. This is supported by the survey data. Risks of the procedure, including alternatives such as cardiopulmonary bypass, alternative valve replacement technique, or discontinuation of the procedure would be discussed during the consent conversation. In preparation for the procedure, each physician will independently review the patient's laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram and primary CT and angiographic images from prior studies. The physicians determine appropriate antiplatelet and other pharmacologic therapy. The physician's must also coordiante with each other prior to the procedure to determine the final operative stratagey for the procedure. The Expert Panel felt that adding additional evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians as discussed above.

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case for a total of 15 minutes. This is the current positioning time for these codes and the time is also supported by the survey data. The codes represent hybrid procedures each with the possibility of emergency cardiopulmonary bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency of the procedures. In addition, the patient must be positioned for all the approaches plus the induction of cardiopulmonary bypass for each of the cardiopulmonary bypass procedures.

SAME DAY IMMEDIATE POST TIME

Post service time package 9B General Anesthesia/Complex Patient was selected for all six codes. The 33363 survey median post time was 30 minutes. However, one response from the median the immediate post-service time was 45 minutes. This 45 minutes would be more consistent with the other open codes in the family. The specialties are recommending an increase of 12 minutes over the package time for a total time of 45 minutes, which is the current post time for the procedure. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

Although 33363 is a 000-day global, the procedure is considered a major cardiac procedure where the patients will typically stay in the hospital for 4 – 6 days (TVT-R). As with other major surgical procedures that have a 000-day global (e.g. ECMO), the multispecialty team care of the patient will vary significantly by patient and institution and the 000-day global allows for appropriate care from multiple specialties without overlap in work or reimbursement. The survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery was typical. That is consistent with the current valuation as well. The survey respondents indicated that a same-day critical care hospital visit is typical. The initial postoperative course following TAVR is similar to other postoperative cardiac surgery procedures involving a heart valve. Post-op care involves monitoring of the patient's hemodynamic condition, including cardiac rhythm, rate and conduction abnormalities. Cardiac arrhythmias are assessed. Atrial extrasystoles, either isolated or in prolonged runs are differentiated from ventricular extrasystoles or runs which are correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed as appropriate based on monitoring lines that are utilized for each patient. Filling pressures (central venous pressure, pulmonary artery diastolic pressure and left atrial ("wedge" pressure) are correlated at baseline and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and

minimize adverse end-organ effects. Peripheral perfusion, with special emphasis on end-organ perfusion, is carefully evaluated by observation and physical exam, correlating findings with invasive monitoring results. Any TAVR performed via a peripheral artery access necessitates a detailed assessment of distal arterial perfusion and vascular integrity of the artery. In addition, the vascular access wounds will be assessed as part of standard wound care. The critical care visit covers the time that both physicians independently spend with the patient directly related to the procedure providing critical care services the same day after the procedure. The services provided do not overlap and are not duplicative with each physician managing and evaluating the patient from different post-operative perspectives. The survey supported a single critical care visit and the Expert Panel agreed. Other 000 codes with same-day visits include several ECMO codes (starting at 33951) and thoracoscopy codes (starting at 32601).

33363

Code 33363 in this family is open axillary transcatheter placement of a prosthetic aortic valve. The expert panel **recommends the survey 25th-percentile value of 28.25 work RVUs for 33363, with 50 minutes preservice time, 100 minutes intraservice time from the survey median, 45 minutes postservice time, and one same-day 99291.** This small increase in rank order represents a decrease in time and RVU from the RUC's 2012 recommendations. It also builds a correct rank order from the prior code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33363

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty interventional cardiology How often? Rarely

Specialty cardiothoracic surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1350

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. These patients are almost universally Medicare age. With roughly a third of Medicare beneficiaries in MA plans, the 1350 in this estimate adds 50% to our FFS estimate below.

Specialty interventional cardiology Frequency 675 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 675 Percentage 50.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 900
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. FFS utilization has grown but remained in the hundreds since the first devices came to market in 2011. This estimate assumes similar growth from 2016 to 2017 as from 2015 to 2016.

Specialty interventional cardiology Frequency 450 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 450 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33363

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33364 Tracking Number Original Specialty Recommended RVU: **28.75**
Presented Recommended RVU: **25.97**
Global Period: 000 Current Work RVU: **30.00** RUC Recommended RVU: **25.97**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 82-year-old female presents with symptomatic aortic stenosis, hypertension, peripheral artery disease, Class III-IV heart failure and an STS Risk score of 7.6. The aortic stenosis is life-limiting with a documented aortic valve orifice area of 0.6 cm2. She is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who recommend percutaneous transcatheter aortic valve replacement. Severe peripheral vascular disease of bilateral femoral arteries precludes percutaneous or open surgical approach to either artery. An open surgical approach to the patient's iliac artery for device delivery is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 68%

Description of Pre-Service Work: The patient's history, records, and laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary angiogram, and transthoracic echocardiogram are reviewed and measurements are confirmed. This includes a review of the primary CT and angiographic images from prior studies. A physical examination is conducted. A clinical note is generated that summarizes the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is considered and if appropriate, initiated or continued. Additional preprocedure functions include writing orders for adequate sedation and patient support and reviewing study arrangements and procedures with the technical, nursing, and other assisting personnel. Appropriate communication is conducted with the patient and the patient's family as well as with other medical professionals as needed. The procedure is reviewed with the patient and the patient's family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments, and supplies for the procedure are confirmed to be available and operational. The patient is positioned on the procedural table and attached to cardiac electrodes and an oxygen saturation monitor. Appropriate anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. Pre-procedural echocardiography is performed. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are present. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiographer, and echocardiography technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive. A surgical "time Out" is performed during which confirmation of critical information is ensured, such as the patient's identity, the planned procedure, the access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances that might influence the procedure.

Description of Intra-Service Work: After establishing femoral venous access, a temporary transvenous pacemaker electrode is advanced into the apex of the right ventricle and tested for proper electrical capture. Arterial access (e.g., femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guidewire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

A transverse suprainguinal skin incision is made and a retroperitoneal dissection plane is developed. The dissection is continued deep into the pelvis until the iliac artery is located. Care is taken to avoid injury to the nerves, veins, and ureter that lie in close proximity. The common, internal, and external iliac arteries are dissected and isolated with vessel loops. Intravenous antithrombotic therapy is administered. A longitudinal arteriotomy is made. A graft conduit (a large diameter tubular segment of synthetic bypass graft) is brought onto the field, tailored to appropriate size, and an end-to-side anastomosis of conduit to common iliac artery is performed with a running polypropylene suture . The conduit is clamped and vascular clamps are removed. The suture line is checked for hemostasis and additional sutures are applied as required. Using fluoroscopic guidance, a standard guidewire is advanced to the descending aorta and exchanged for a stiff guidewire with an angiographic catheter. Over the stiff guidewire, a large-bore vessel introducer sheath is inserted and advanced to a level that is inferior to the renal arteries.

Under fluoroscopic guidance, the native aortic valve is crossed using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle, and the wire is exchanged for a stiff guidewire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained and require repositioning. A large balloon catheter is passed over the guidewire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus. (If performed, TEE is separately reported.) Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter, guidewire, and sheath are removed from the patient. The iliac arterial graft site is then clamped with a partial occlusion clamp to isolate the graft, which is excised, leaving a 5- to 6-mm cuff. The graft stump is de-aired and oversewn in two layers with a running polypropylene suture, and the clamp removed. Hemostasis is achieved and protamine is given for reversal. The wound is irrigated and closed in layers. A sterile dressing is applied to the entry site.

Description of Post-Service Work: The physicians confirm the patient's hemodynamic status, including systemic arterial pressure, pulmonary artery pressure, and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to transfer to the intensive care unit. A focused vascular examination of the at-risk extremities is performed to assess for adequate limb perfusion. The patient is also assessed for possible early embolic complications such as stroke requiring a detailed neurologic examination as well as a focused physical examination for possible intra-abdominal catastrophe such as mesenteric ischemia. Postoperative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, and revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the postoperative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory transcathether aortic valve replacement therapy (TAVR) registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Richard Wright, MD; James Levett, MD; Stephen Lahey, MD; Marie-France Poulin, MD; Thad Waites, MD;				
Specialty(s):	ACC, STS, SCAI, AATS				
CPT Code:	33364				
Sample Size:	2535	**Resp N:**	28	**Response:** 1.1 %	
Description of Sample:	1000 interventional cardiologists, 1535 cardiac surgeons				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	5.00	50.00
Survey RVW:	15.20	28.75	**34.25**	35.75	52.00
Pre-Service Evaluation Time:			**51.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	50.00	90.00	**94.00**	125.00	210.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33364	**Recommended Physician Work RVU: 25.97**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**94.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	70.00	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33979	000	37.50	**RUC Time**

CPT Descriptor Insertion of ventricular assist device, implantable intracorporeal, single ventricle

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33976	000	30.75	**RUC Time**

CPT Descriptor Insertion of ventricular assist device; extracorporeal, biventricular

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	10,168

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 35.7 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 33364	Top Key Reference CPT Code: 33979	2nd Key Reference CPT Code: **33976**
Median Pre-Service Time	85.00	95.00	95.00
Median Intra-Service Time	94.00	280.00	240.00
Median Immediate Post-service Time	45.00	120.00	120.00
Median Critical Care Time	70.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**294.00**	**495.00**	**455.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	20%	30%	10%	40%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	40%	60%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	20%	40%	40%
Physical effort required	10%	30%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	40%	60%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	29%	29%	14%	29%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	29%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	43%	57%
Physical effort required	14%	29%	57%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	43%	57%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Code 33364 describes the open iliac approach for transcatheter placement of an aortic valve replacement prosthesis. As previously described, surveys were sent to 2,535 physicians (1535 STS members who self-identify as adult cardiac surgeons and 1000 interventional cardiologist). An Expert Panel with representatives from the American College of Cardiology (ACC), Society of Thoracic Surgeons (STS), American Association for Thoracic Surgery (AATS) and the Society

for Cardiac Angiography and Interventions (SCAI) was convened to review the RUC survey results and TVT Registry data and finalize the recommendations.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient.

ADDITIONAL EVALUATION TIME

For the evaluation, the Expert Panel is recommending an increase of 10 minutes over the package for a total evaluation time of 50 minutes for all codes in the family. This is supported by the survey data. Risks of the procedure, including alternatives such as cardiopulmonary bypass, alternative valve replacement technique, or discontinuation of the procedure would be discussed during the consent conversation. In preparation for the procedure, each physician will independently review the patient's laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram and primary CT and angiographic images from prior studies. The physicians determine appropriate antiplatelet and other pharmacologic therapy. The physician's must also coordiante with each other prior to the procedure to determine the final operative stratagey for the procedure. The Expert Panel felt that adding additional evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians as discussed above.

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case for a total of 15 minutes. This is the current positioning time for these codes and the time is also supported by the survey data. The codes represent hybrid procedures each with the possibility of emergency cardiopulmonary bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency of the procedures. In addition, the patient must be positioned for all the approaches plus the induction of cardiopulmonary bypass for each of the cardiopulmonary bypass procedures.

SAME DAY IMMEDIATE POST TIME

Post service time package 9B General Anesthesia/Complex Patient was selected for all six codes. The 33364 survey supported 45 minutes of immediate post time. The specialties are recommending an increase of 12 minutes over the package time for a total time of 45 minutes, which is the current post time for the procedure. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

Although 33364 is a 000-day global, the procedure is considered a major cardiac procedure where the patients will typically stay in the hospital for 4 – 6 days (TVT-R). As with other major surgical procedures that have a 000-day global (e.g. ECMO), the multispecialty team care of the patient will vary significantly by patient and institution and the 000-day global allows for appropriate care from multiple specialties without overlap in work or reimbursement. The survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery was typical. That is consistent with the current valuation as well. The survey respondents indicated that a same-day critical care hospital visit is typical. The initial postoperative course following TAVR is similar to other postoperative cardiac surgery procedures involving a heart valve. Post-op care involves monitoring of the patient's hemodynamic condition, including cardiac rhythm, rate and conduction abnormalities. Cardiac arrhythmias are assessed. Atrial extrasystoles, either isolated or in prolonged runs are differentiated from ventricular extrasystoles or runs which are correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed as appropriate based on monitoring lines that are utilized for each patient. Filling pressures (central venous pressure, pulmonary artery diastolic pressure and left atrial ("wedge" pressure) are correlated at baseline and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion, with special emphasis on end-organ perfusion, is carefully

evaluated by observation and physical exam, correlating findings with invasive monitoring results. Any TAVR performed via a peripheral artery access necessitates a detailed assessment of distal arterial perfusion and vascular integrity of the artery. In addition, the vascular access wounds will be assessed as part of standard wound care. The critical care visit covers the time that both physicians independently spend with the patient directly related to the procedure providing critical care services the same day after the procedure. The services provided do not overlap and are not duplicative with each physician managing and evaluating the patient from different post-operative perspectives. The survey supported a single critical care visit and the Expert Panel agreed. Other 000 codes with same-day visits include several ECMO codes (starting at 33951) and thoracoscopy codes (starting at 32601).

33364

Code 33364 in this family is open iliac transcatheter placement of a prosthetic aortic valve. The expert panel **recommends the survey 25th-percentile value of 28.75 work RVUs for 33364, with 50 minutes preservice time, 94 minutes intraservice time from the survey median, 45 minutes postservice time, and one same-day 99291.** This represents a decrease in time and RVU from the RUC's 2012 recommendations. Despite the small drop in time from the prior code, this code was correctly assessed by respondents to be more intense and have a slightly higher value than 33363. In part that would be due to the rarity of this service—only 33 were performed in 2016 PFS data.

Finally, with this code, we recommend the RUC waive its normal requirement for 30 survey responses. Repeated attempts to encourage survey completion did not produce that number of responses. The response pool only barely had an experience of 1 with this service. We do not predict resurvey would be any more likely to attain 30 responses or to produce a meaningfully different result for this low volume service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33364

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty interventional cardiology How often? Rarely

Specialty cardiothoracic surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 48
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. These patients are almost universally Medicare age. WIth roughly a third of Medicare beneficiaries in MA plans, the 48 in this estimate adds 50% to our FFS estimate below.

Specialty interventional cardiology Frequency 24 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 24 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 32 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. FFS utilization started small and has declined since the first devices came to market in 2011. This estimate is similar to 2016 utilization. Specialty estimates split utilization evenly as services must be billed using cosurgery modifier 62.

Specialty interventional cardiology Frequency 15000 Percentage 46,875.00 %

Specialty cardiothoracic surgery Frequency 15000 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33364

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33365 Tracking Number Original Specialty Recommended RVU: **34.00**
Presented Recommended RVU: **26.59**
Global Period: 000 Current Work RVU: **33.12** RUC Recommended RVU: **26.59**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 82-year-old female presents with symptomatic aortic stenosis, hypertension, peripheral artery disease, Class III-IV heart failure and an STS Risk score of 7.6. The aortic stenosis is life-limiting with a documented aortic valve orifice area of 0.6 cm2. She is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who recommend percutaneous transcatheter aortic valve replacement. However, because of severe peripheral vascular disease, including severe aortoiliac, femoral and axillary artery disease, percutaneous or direct approach to these vessels for device delivery is impossible. Significant pulmonary disease precludes the apical left ventricular approach via left thoracotomy is. A direct aortic approach via either median sternotomy or mediastinotomy is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 65%

Description of Pre-Service Work: The patient's history, records, and laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary angiogram, and transthoracic echocardiogram, are reviewed and measurements are confirmed. This includes a review of the primary CT and angiographic images from prior studies. A physical examination is conducted. A clinical note is generated that summarizes the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is considered and if appropriate, initiated or continued.. Additional pre-procedure functions include writing orders for adequate sedation and patient support and reviewing study arrangements and procedures with the technical, nursing, and other assisting personnel. Appropriate communication is conducted with the patient and the patient's family as well as with other medical professionals as needed. The procedure is reviewed with the patient and the patient's family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments, and supplies for the procedure are confirmed to be available and operational. The patient is positioned on the procedural table and attached to cardiac electrodes and an oxygen saturation monitor. Appropriate anesthesia is induced by the anesthesiology team. External defibrillator pads are placed on the anterior and posterior chest. Pre-procedural echocardiography is performed. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments/supplies are present. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists are also positioned at the operative field. In addition, all other personnel including anesthesiologists, circulating nurses, respiratory therapists, echocardiographer, and echocardiography technicians are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive. A surgical "Time Out" is performed during which confirmation of critical information is ensured, such as the patient's identity, the planned procedure, the access route,

allergies, signed consent, availability of proper equipment, and any unusual circumstances that might influence the procedure.

Description of Intra-Service Work: After establishing femoral venous access, a temporary transvenous pacemaker electrode is advanced into the apex of the right ventricle and tested for proper electrical capture. Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guidewire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is/are obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

A full or partial median sternotomy incision is performed. Dissection of the thymic fat pad reveals the pericardium, which is opened vertically. Sutures are used to retract and expose the ascending aorta. Alternatively, an anterior mediastinotomy is performed to provide access to the ascending aorta. Antithromotic therapy is begun. Epiaortic ultrasonic scanning is performed to identify a disease-free site for sheath delivery. A pledgeted double pursestring suture is placed in the mid ascending aorta, and the adventia is locally dissected within the pursestring. The aorta is opened with a knife, the large-bore vascular sheath is introduced, and the pursestring suture is tightened to achieve hemostasis.

Under fluoroscopic guidance, the native aortic valve is crossed using a guidewire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guidewire is across the aortic valve and positioned in the left ventricle, a small catheter is advanced over the wire into the left ventricle, and the wire is exchanged for a stiff guidewire. Ventricular ectopy induced by the catheter/wire is frequent and may be sustained and require repositioning. A large balloon catheter is passed over the guidewire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guidewire while maintaining access across the native aortic valve. The delivery catheter is advanced to the aortic root and positioned across the native aortic valve annulus under fluoroscopic guidance. In addition, transesophageal echocardiography may be used to position the prosthesis within the aortic annulus. (If performed, TEE is separately reported.) Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter and guidewire are removed from the patient. The sheath is removed from the ascending aorta and the aortic double pursestring suture is tied. Additional sutures may be required for hemostasis. The pericardium is closed over a single drain. Protamine is given for reversal. Appropriate mediastinal chest tubes are placed and brought out through the skin, inferior to the incision. After achieving satisfactory hemostasis, the sternum is reapproximated with stainless steel wires. The wound is irrigated and closed in layers. A sterile dressing is applied.

Description of Post-Service Work: The physicians confirm the patient's hemodynamic status, including systemic arterial pressure, pulmonary artery pressure, and the patient's heart rhythm, prior to removing the patient from the operating room and committing the patient to transfer to the intensive care unit. The patient is assessed for possible early embolic complications such as stroke requiring a detailed neurologic examination as well as a focused physical examination for possible limb ischemia or intra-abdominal catastrophe such as mesenteric ischemia. The stability of the sternal closure is assessed and the patency of the chest tubes is ensured. Postoperative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, and revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the post-operative care givers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory transcathether aortic valve replacement therapy (TAVR) registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Richard Wright, MD; James Levett, MD; Stephen Lahey, MD; Marie-France Poulin, MD; Thad Waites, MD;				
Specialty(s):	ACC, STS, SCAI, AATS				
CPT Code:	33365				
Sample Size:	2535	**Resp N:**	31	**Response:** 1.2 %	
Description of Sample:	1000 interventional cardiologists, 1535 cardiac surgeons				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	5.00	50.00
Survey RVW:	15.50	34.00	**35.00**	37.75	54.00
Pre-Service Evaluation Time:			**73.00**		
Pre-Service Positioning Time:			**18.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	93.00	**120.00**	145.00	240.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33365	**Recommended Physician Work RVU: 26.59**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33979	000	37.50	**RUC Time**

CPT Descriptor Insertion of ventricular assist device, implantable intracorporeal, single ventricle

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33976	000	30.75	**RUC Time**

CPT Descriptor Insertion of ventricular assist device; extracorporeal, biventricular

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	10,168

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 35.4 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 19.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 33365	Top Key Reference CPT Code: 33979	2nd Key Reference CPT Code: **33976**
Median Pre-Service Time	85.00	95.00	95.00
Median Intra-Service Time	120.00	280.00	240.00
Median Immediate Post-service Time	45.00	120.00	120.00
Median Critical Care Time	70.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**320.00**	**495.00**	**455.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	18%	36%	9%	36%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	36%	55%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	36%	46%
Physical effort required	0%	55%	45%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	45%	55%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	50%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	100%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	33%	50%
Physical effort required	17%	50%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	67%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Code 33365 describes the transaortic approach through a sternotomy for transcatheter placement of an aortic valve replacement prosthesis. As previously described, surveys were sent to 2,535 physicians (1535 STS members who self-identify as adult cardiac surgeons and 1000 interventional cardiologist). An Expert Panel with representatives from the American College of Cardiology (ACC), Society of Thoracic Surgeons (STS), American Association for Thoracic Surgery

(AATS) and the Society for Cardiac Angiography and Interventions (SCAI) was convened to review the RUC survey results and TVT Registry data and finalize the recommendations.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel recommends increases in time for the evaluation of the patient and for the positioning of the patient.

ADDITIONAL EVALUATION TIME

For the evaluation, the Expert Panel recommends an increase of 10 minutes over the package for a total evaluation time of 50 minutes for all codes in the family. This is supported by the survey data. Risks of the procedure, including alternatives such as cardiopulmonary bypass, alternative valve replacement technique, or discontinuation of the procedure would be discussed during the consent conversation. In preparation for the procedure, each physician will independently review the patient's laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram and primary CT and angiographic images from prior studies. The physicians determine appropriate antiplatelet and other pharmacologic therapy. The physician's must also coordiante with each other prior to the procedure to determine the final operative stratagey for the procedure. The Expert Panel felt that adding additional evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians as discussed above.

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case for a total of 15 minutes. This is the current positioning time for these codes and the time is also supported by the survey data. The codes represent hybrid procedures each with the possibility of emergency cardiopulmonary bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency of the procedures. In addition, the patient must be positioned for all the approaches plus the induction of cardiopulmonary bypass for each of the cardiopulmonary bypass procedures.

SAME DAY IMMEDIATE POST TIME

Post service time package 9B General Anesthesia/Complex Patient was selected for all six codes. The 33365 survey supported 45 minutes of immediate post time. The specialties are recommending an increase of 12 minutes over the package time for a total time of 45 minutes, which is the current post time for the procedure. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

Although 33365 is a 000-day global, the procedure is considered a major cardiac procedure where the patients will typically stay in the hospital for 4 – 6 days (TVT-R). As with other major surgical procedures that have a 000-day global (e.g. ECMO), the multispecialty team care of the patient will vary significantly by patient and institution and the 000-day global allows for appropriate care from multiple specialties without overlap in work or reimbursement. The survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery was typical. That is consistent with the current valuation as well. The survey respondents indicated that a same-day critical care hospital visit is typical. The initial postoperative course following TAVR is similar to other postoperative cardiac surgery procedures involving a heart valve. Post-op care involves monitoring of the patient's hemodynamic condition, including cardiac rhythm, rate and conduction abnormalities. Cardiac arrhythmias are assessed. Atrial extrasystoles, either isolated or in prolonged runs are differentiated from ventricular extrasystoles or runs which are correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed as appropriate based on monitoring lines that are utilized for each patient. Filling pressures (central venous pressure, pulmonary artery diastolic pressure and left atrial ("wedge" pressure) are correlated at baseline and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion, with special emphasis on end-organ perfusion, is carefully

evaluated by observation and physical exam, correlating findings with invasive monitoring results. The median sternotomy wound associated with 33365 will be evaluated for abnormal drainage, sternal instability, etc. Chest tubes placed prior to closure of the sternotomy wound will be assessed for excessive blood loss and air leaks. The critical care visit covers the time that both physicians independently spend with the patient directly related to the procedure providing critical care services the same day after the procedure. The services provided do not overlap and are not duplicative with each physician managing and evaluating the patient from different post-operative perspectives. The survey supported a single critical care visit and the Expert Panel agreed. Other 000 codes with same-day visits include several ECMO codes (starting at 33951) and thoracoscopy codes (starting at 32601).

33365

Code 33365 in this family is transaortic transcatheter placement of a prosthetic aortic valve through a sternotomy. The expert panel **recommends the survey 25th-percentile value of 34.00 work RVUs for 33365, with 50 minutes preservice time, 120 minutes intraservice time from the survey median, 45 minutes postservice time, and one same-day 99291.** This represents a decrease in time and RVU from the RUC's 2012 recommendations. It also builds correctly off 33364 by allowing an increment for moving from an open artery approach to a sternotomy approach.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33365

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty interventional cardiology How often? Rarely

Specialty cardiothoracic surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. These patients are almost universally Medicare age. With roughly a third of Medicare beneficiaries in MA plans, the 600 in this estimate adds 50% to our FFS estimate below.

Specialty interventional cardiology Frequency 300 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 300 Percentage 50.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. FFS tilization grew then declined since first devices came to market in 2011. This estimate is comparable to 2016 utilization. Specialty estimates split utilization evenly as services must be billed using cosurgery modifier 62.

Specialty interventional cardiology Frequency 200 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 200 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33365

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33366 Tracking Number Original Specialty Recommended RVU: **34.50**
Presented Recommended RVU: **29.35**
Global Period: 000 Current Work RVU: **35.88** RUC Recommended RVU: **29.35**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 83-year-old female presents with symptomatic aortic stenosis, hypertension, peripheral artery disease, Class III-IV heart failure and an STS Risk score of 10.4. The aortic stenosis is life-limiting with a documented aortic valve orifice area of 0.6 cm2. She is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who recommends percutaneous transcatheter aortic valve replacement. Because of severe peripheral vascular disease, including severe aortoiliac, femoral, and axillary artery disease, neither a percutaneous or open approach to these vessels was possible for safe prosthesis delivery. In addition, the presence of a “porcelain” aorta precludes a direct approach to the aorta via median sternotomy. A trans apical approach through limited thoracotomy is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 61%

Description of Pre-Service Work: The patient's history, records, and laboratory and diagnostic tests, including CT angiogram, coronary angiogram, and transthoracic echocardiogram, are reviewed and measurements are confirmed. This includes review of the primary CT and angiographic images from prior studies. Physical examination is conducted. A clinical note is generated summarizing the clinical information if a recent note is not available. The patient is prepared for the procedure with careful documentation of baseline clinical findings such as vital signs, arterial pulses, allergies, electrocardiographic findings, laboratory results, family contact information, and other data. Appropriate antiplatelet and other pharmacologic therapy important for patient safety is considered and if appropriate, initiated or continued.. Additional pre-procedure functions include writing orders for adequate sedation and patient support and a review of study arrangements and procedures with technical, nursing, and other assisting personnel. Appropriate communication is conducted with the patient and family as well as other medical professionals, as needed. The procedure is reviewed with the patient and family. The risks and benefits of the procedure are presented, as well as the alternatives. Informed consent is obtained. Necessary equipment, instruments, and supplies for the procedure are confirmed to be available and operational. The patient is positioned on the procedural table and attached to cardiac electrodes and an oxygen saturation monitor. Appropriate anesthesia is induced by the anesthesiology team. The patient is intubated with a double-lumen endotracheal tube. External defibrillator pads are placed on the anterior and posterior chest. Pre-procedural echocardiography is performed. A sterile table is prepared. All cardiopulmonary bypass equipment and specialized instruments and supplies are present. Critical personnel, including surgeons, interventional cardiologists, nurses, technicians, and perfusionists, are also positioned at the operative field. In addition, all other personnel, including anesthesiologists, circulating nurses, respiratory therapists, echocardiographer, and echo technicians, are in place, performing their specialized duties. The patient is prepped and draped for all possible alternative access sites and possible open surgical approaches. The injection manifold and hemodynamic monitoring tubes and cables are set up. The patient's information is loaded in the hemodynamic monitoring equipment and into the angiographic digital archive .A "time out" occurs during which confirmation of critical information

is ensured, such as the patient's identity, planned procedure, access route, allergies, signed consent, availability of proper equipment, and any unusual circumstances that might influence the procedure.

Description of Intra-Service Work: After establishing femoral venous access, a temporary transvenous pacemaker electrode is advanced into the apex of the right ventricle and tested for proper electrical capture.

Arterial access (eg, femoral, radial, or brachial) for the reference pigtail catheter is obtained by needle puncture (Seldinger technique), followed by passage of a standard guide wire and pigtail angiographic catheter. The catheter is positioned within the aortic root using fluoroscopy. A root aortogram(s) is obtained using power contrast injection and cine angiography to determine the optimal angiographic angle relative to the native aortic valve.

The heart is exposed through a left anterior thoracotomy in the fifth or sixth intercostal space . Single lung ventilation is initiated, and the left lung is collapsed. A pericardiotomy is performed and pacing wires are affixed to the ventricular muscle. Two circumferential pledgeted purse-string sutures are placed in the apex of the left ventricle. Anticoagulant therapy is administered to achieve therapeutic anticoagulation levels. A large-bore sheath is introduced into the left ventricle and a pigtail catheter advanced over a guide wire into the ascending aorta using fluoroscopy.

Under fluoroscopic guidance, the native aortic valve is crossed using a guide wire and catheter of the physician's choice. This typically requires multiple attempts and multiple angiographic views due to the severe aortic valve stenosis. Once the guide wire is across the aortic valve and positioned in the aorta, a small catheter is advanced over the wire, and the wire is exchanged for a stiff guide wire. A large balloon catheter is passed over the guide wire and positioned within the native aortic valve. Rapid pacing is initiated to minimize balloon movement, and balloon aortic valvuloplasty is performed: the balloon is inflated by one physician while another physician continuously adjusts the balloon catheter position to minimize any potential movement and resultant left ventricular trauma/perforation. Typically, this results in hypotension and ventricular ectopy. The balloon is then rapidly deflated, and the patient is monitored for hemodynamic recovery. Supravalvular aortography is performed to assess the aorta and ventricle for trauma and to assess for aortic insufficiency. Concurrently, the prosthetic valve is loaded into or onto the delivery catheter. Correct orientation of the valve on the delivery catheter is confirmed by the physician before inserting the valve-delivery catheter system into the introducer sheath. The valvuloplasty catheter is exchanged for the prosthetic delivery catheter over the previously positioned stiff guide wire while maintaining access across the native aortic valve. The delivery catheter is advanced across the native aortic valve annulus to the aortic root and positioned under fluoroscopic guidance. In addition, transesophageal echocardiography (TEE) may be used to position the prosthesis within the aortic annulus (if performed, TEE is separately reported). Multiple supravalvular aortograms may be performed to facilitate placement before a satisfactory valve position is chosen. The prosthesis is then deployed within the native aortic valve, typically during rapid ventricular pacing.

After confirming satisfactory position and function of the valve, as well as assessing the degree of any paravalvular regurgitation or the presence of mechanical complications that might require open, urgent surgical intervention or coronary compromise requiring percutaneous coronary intervention, the delivery catheter and guide wire are removed from the patient.

The left ventricular apical sheath is removed, and the purse-string sutures are tied and reinforced if necessary. Hemostasis is assured. Protamine is given to reverse the heparin. Chest tube(s) is placed. Double lung ventilation is resumed. The incision is closed in layers and dressings are placed.

Description of Post-Service Work: The physicians confirm the patient’s hemodynamic status, including systemic arterial pressure, pulmonary artery pressure, and heart rhythm, prior to removing the patient from the operating room and committing the patient to ICU transfer. The patient is assessed for possible early embolic complications such as stroke requiring a detailed neurologic examination as well as a focused physical examination for possible limb ischemia or intra-abdominal catastrophe such as mesenteric ischemia. The patency of the post thoracotomy chest tube(s) is ensured. Proper position of the chest tube(s) is confirmed by chest x-ray as is the absence of post operative pneumothorax. Postoperative orders are written. A detailed "hand-off" process is initiated in which procedure results are reviewed with the accepting nursing staff and other physicians, as well as with other members of the health care team. The patient's fluoroscopic exposure time and total contrast volume administered are reviewed and recorded. Procedure notes are dictated, reviewed, and revised as necessary to provide an accurate accounting of the procedure performed as well as any possible complications or events that would require special attention by the postoperative caregivers. The dictated summary is signed. Data relating to the patient and the procedure performed are immediately entered into the mandatory TAVR registry by the two procedural physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018		
Presenter(s):	Richard Wright, MD; James Levett, MD; Stephen Lahey, MD; Marie-France Poulin, MD; Thad Waites, MD;		
Specialty(s):	ACC, STS, SCAI, AATS		
CPT Code:	33366		
Sample Size:	2535	**Resp N:** 31	**Response:** 1.2 %
Description of Sample:	1000 interventional cardiologists, 1535 cardiac surgeons		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	5.00	50.00
Survey RVW:	15.50	34.50	**37.00**	40.00	60.00
Pre-Service Evaluation Time:			**70.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	60.00	90.00	**120.00**	145.00	240.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33366	**Recommended Physician Work RVU: 29.35**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	70.00	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33979	000	37.50	**RUC Time**

CPT Descriptor Insertion of ventricular assist device, implantable intracorporeal, single ventricle

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33982	000	37.86	**RUC Time**

CPT Descriptor Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	10,168

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 25.8 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 19.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 33366	Top Key Reference CPT Code: 33979	2nd Key Reference CPT Code: **33982**
Median Pre-Service Time	85.00	95.00	95.00
Median Intra-Service Time	120.00	280.00	290.00
Median Immediate Post-service Time	45.00	120.00	90.00
Median Critical Care Time	70.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**320.00**	**495.00**	**475.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	38%	38%	25%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	25%	57%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	38%	62%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	17%	50%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	33%	67%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Code 33366 describes the transapical approach through a thoracotomy for transcatheter placement of an aortic valve replacement prosthesis. As previously described, surveys were sent to 2,535 physicians (1535 STS members who self-identify as adult cardiac surgeons and 1000 interventional cardiologist). An Expert Panel with representatives from the American College of Cardiology (ACC), Society of Thoracic Surgeons (STS), American Association for Thoracic Surgery

(AATS) and the Society for Cardiac Angiography and Interventions (SCAI) was convened to review the RUC survey results and TVT Registry data and finalize the recommendations.

PRE-TIME CHANGES

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel recommends increases in time for the evaluation of the patient and for the positioning of the patient.

ADDITIONAL EVALUATION TIME

For the evaluation, the Expert Panel recommends an increase of 10 minutes over the package for a total evaluation time of 50 minutes for all codes in the family. This is supported by the survey data. Risks of the procedure, including alternatives such as cardiopulmonary bypass, alternative valve replacement technique, or discontinuation of the procedure would be discussed during the consent conversation. In preparation for the procedure, each physician will independently review the patient's laboratory and diagnostic tests, including computed tomographic (CT) angiogram, coronary and ilio-femoral contrast angiogram, transthoracic echocardiogram, transesophageal echocardiogram and primary CT and angiographic images from prior studies. The physicians determine appropriate antiplatelet and other pharmacologic therapy. The physician's must also coordiante with each other prior to the procedure to determine the final operative stratagey for the procedure. The Expert Panel felt that adding additional evaluation time to package 4 was reasonable and would cover all aspects of the same day pre-service work involved with the procedure by both physicians as discussed above.

ADDITIONAL POSITIONING TIME

For the positioning, an additional 12 minutes was added to each case for a total of 15 minutes. This is the current positioning time for these codes and the time is also supported by the survey data. The codes represent hybrid procedures each with the possibility of emergency cardiopulmonary bypass. The positioning for these procedures is unique in that there is more equipment involved and that the surgeons need to plan and position for each contingency of the procedures. In addition, the patient must be positioned for all the approaches plus the induction of cardiopulmonary bypass for each of the cardiopulmonary bypass procedures.

SAME DAY IMMEDIATE POST TIME

Post service time package 9B General Anesthesia/Complex Patient was selected for all six codes. The 33366 survey supported 45 minutes of immediate post time. The specialties are recommending an increase of 12 minutes over the package time for a total time of 45 minutes, which is the current post time for the procedure. There are numerous examples in the RUC database supporting this time.

SAME DAY POST PROCEDURE VISIT

Although 33366 is a 000-day global, the procedure is considered a major cardiac procedure where the patients will typically stay in the hospital for 4 – 6 days (TVT-R). As with other major surgical procedures that have a 000-day global (e.g. ECMO), the multispecialty team care of the patient will vary significantly by patient and institution and the 000-day global allows for appropriate care from multiple specialties without overlap in work or reimbursement. The survey respondents replied 100% that the procedure was performed in the hospital, that the patient stayed overnight for more than 24 hours, and that a visit was provided the same day of surgery was typical. That is consistent with the current valuation as well. The survey respondents indicated that a same-day critical care hospital visit is typical. The initial postoperative course following TAVR is similar to other postoperative cardiac surgery procedures involving a heart valve. Post-op care involves monitoring of the patient's hemodynamic condition, including cardiac rhythm, rate and conduction abnormalities. Cardiac arrhythmias are assessed. Atrial extrasystoles, either isolated or in prolonged runs are differentiated from ventricular extrasystoles or runs which are correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed as appropriate based on monitoring lines that are utilized for each patient. Filling pressures (central venous pressure, pulmonary artery diastolic pressure and left atrial ("wedge" pressure) are correlated at baseline and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion, with special emphasis on end-organ perfusion, is carefully

evaluated by observation and physical exam, correlating findings with invasive monitoring results. The thoracotomy wound associated with 33366 is assessed for stability of the chest wall, abnormal drainage, etc. Chest tubes placed prior to closure of the thoracotomy wound are assessed for excessive blood loss and air leaks. Post procedure chest x-ray is reviewed for post-operative pneumothorax. The critical care visit covers the time that both physicians independently spend with the patient directly related to the procedure providing critical care services the same day after the procedure. The services provided do not overlap and are not duplicative with each physician managing and evaluating the patient from different post-operative perspectives. The survey supported a single critical care visit and the Expert Panel agreed. Other 000 codes with same-day visits include several ECMO codes (starting at 33951) and thoracoscopy codes (starting at 32601).

33366

Code 33366 in this family is transapical transcatheter placement of a prosthetic aortic valve through a thoracotomy. The expert panel **recommends the survey 25th-percentile value of 34.50 work RVUs for 33366, with 50 minutes preservice time, 120 minutes intraservice time from the survey median, 45 minutes postservice time, and one same-day 99291.** This represents a decrease in time and RVU from the RUC's 2012 recommendations. also builds correctly off 33364 by allowing an increment for moving from an open artery approach to a thoracotomy approach. This increment is slightly greater than for the previous code for transaortic placement through a sternotomy.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33366

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty interventional cardiology How often? Rarely

Specialty cardiothoracic surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 925
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. These patients are almost universally Medicare age. With roughly a third of Medicare beneficiaries in MA plans, the 925 in this estimate adds 50% to our FFS estimate below.

Specialty interventional cardiology Frequency 463 Percentage 50.05 %

Specialty cardiothoracic surgery Frequency 462 Percentage 49.94 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 650
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. FFS utilization declined since the first devices came to market in 2011. This estimate is comparable to 2016 utilization. Specialty estimates split utilization evenly as services must be billed using cosurgery modifier 62.

Specialty interventional cardiology Frequency 325 Percentage 50.00 %

Specialty cardiothoracic surgery Frequency 325 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33366

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.
Hide columns and rows that do not contain data.
1st REF = Top Key Reference code data
2st REF = Second Highest Key Reference code data
CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.
SVY = Survey data - as it appears on the Summary of Recommendation form.
REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Transcatheter Aortic Valve Replacement

TAB: 11

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED/ Mean	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
1st REF	33477	Transcatheter pulmonary valve	23	0.129			25.00			276	40	3	20			180			33																	
2nd REF	33976	Insertion of ventricular assist d	4	0.109			30.75			455	60	15	20			240			120																	
CURRENT	33361	Transcatheter aortic valve repla		0.134			25.13			330	45	15	20			135			45	1																
SVY	33361	Transcatheter aortic valve repla	36	0.221	13.50	25.00	27.00	32.75	48.00	288	63	15	20	30	60	90	120	140	30	1												5	38	69	120	300
TVT Data	33361	Transcatheter aortic valve replac	27698													92																			
TVT Data	33361	Transcatheter aortic valve replac	27698													107																			
REC	33361	Transcatheter aortic valve repla		0.174			22.47			275	50	15	20			90			30	1																

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED/ Mean	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
1st REF	33976	Insertion of ventricular assist d	15	0.109			30.75			455	60	15	20			240			120																	
2nd REF	33477	Transcatheter pulmonary valve	9	0.129			25.00			276	40	3	20			180			33																	
CURRENT	33362	Transcatheter aortic valve repla		0.137			27.52			345	45	15	20			150			45	1																
SVY	33362	Transcatheter aortic valve repla	35	0.265	13.75	28.00	31.00	35.00	53.55	290	50	15	20	45	80	90	120	150	45	1												0	2	5	15	140
TVT Data	33362	Transcatheter aortic valve replac	4448													103																			
TVT Data	33362	Transcatheter aortic valve replac	4448													117																			
REC	33362	Transcatheter aortic valve repla		0.169			24.54			303	50	15	20			103			45	1																

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED/ Mean	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
1st REF	33976	Insertion of ventricular assist d	11	0.109			30.75			455	60	15	20			240			120																	
2nd REF	33477	Transcatheter pulmonary valve	7	0.129			25.00			276	40	3	20			180			33																	
CURRENT	33363	Transcatheter aortic valve repla		0.119			28.50			375	45	15	20			180			45	1																
SVY	33363	Transcatheter aortic valve repla	31	0.249	14.00	28.25	32.00	36.50	55.55	297	62	15	20	50	90	100	120	180	30	1												0	1	2	5	50
REC	33363	Transcatheter aortic valve repla		0.183			25.47			300	50	15	20			100			45	1																

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED/ Mean	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
1st REF	33979	Insertion of ventricular assist d	10	0.118			37.50			495	60	15	20			280			120																	
2nd REF	33976	Insertion of ventricular assist d	7	0.109			30.75			455	60	15	20			240			120																	
CURRENT	33364	Transcatheter aortic valve repla		0.128			30.00			375	45	15	20			180			45	1																
SVY	33364	Transcatheter aortic valve repla	28	0.288	15.20	28.75	34.25	35.75	52.00	295	51	15	20	50	90	94	125	210	45	1												0	0	1	5	50
REC	33364	Transcatheter aortic valve repla		0.200			25.97			294	50	15	20			94			45	1																

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED/ Mean	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX
1st REF	33979	Insertion of ventricular assist d	11	0.118			37.50			495	60	15	20			280			120																	
2nd REF	33976	Insertion of ventricular assist d	6	0.109			30.75			455	60	15	20			240			120																	

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AF	AG	AH	AI	AJ	AO	AP	AQ	AR	AS	AT	AU	AV	AW
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE								
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED/ Mean	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX				
66	CURRENT	33365	Transcatheter aortic valve repla		0.144			33.12			380	50	15	20			180			45	1																				
67	SVY	33365	Transcatheter aortic valve repla	31	0.227	15.50	34.00	35.00	37.75	54.00	346	73	18	20	60	93	120	145	240	45	1												0	1	2	5	50				
68	REC	33365	Transcatheter aortic valve repla		0.162			26.59			320	50	15	20			120			45	1																				
72																																									
73						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							Office					SURVEY EXPERIENCE								
74	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED/ Mean	75th	MAX	POST	91	92	33	32	31	38	39	15	14	13	12	11	MIN	25th	MED	75th	MAX				
75	1st REF	33979	Insertion of ventricular assist d	8	0.118			37.50			495	60	15	20			280			120																				
76	2nd REF	33982	Replacement of ventricular assi	6	0.117			37.86			475	60	15	20			290			90																				
77	CURRENT	33366	Transcatheter aortic valve repla		0.147			35.88			395	50	15	20			195			45	1																				
78	SVY	33366	Transcatheter aortic valve repla	31	0.245	15.50	34.50	37.00	40.00	60.00	340	70	15	20	60	90	120	145	240	45	1												0	0	2	5	50				
79	REC	33366	Transcatheter aortic valve repla		0.185			29.35			320	50	15	20			120			45	1																				

CPT Code: 33361-33366
Specialty Society('s) STS, ACC, AATS, SCAI

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:
33361- Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362- open femoral artery approach
33363- open axillary artery approach
33364- open iliac artery approach
33365- transaortic approach (eg, median sternotomy, mediastinotomy)
33366- transapical approach (eg, left thoracotomy)

Global Period: 000 Meeting Date: April 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: A joint RVS Committee representing the four societies utilized a consensus panel to develop recommended inputs.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: Each of the codes' reference code is the current code and inputs. Prior reference code 33980 is also provided for comparison.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: The standard for 0-day global codes is 0 minutes clinical staff time. TAVR services are exclusively performed in the facility setting and require office staff time typical of 90-day global procedures performed in the facility setting. The TAVR procedures are performed under general anesthesia and the patients typically have an inpatient hospital stay of up 5 or more days. The main reason these codes were assigned a 000 day global period instead of 90 days is to accommodate the post-operative multispecialty care that is shared by the cardiologist and the cardiothoracic surgeon. The existing clinical staff PE inputs were derived from comparison to 33980 for VAD removal. 33980 is an XXX global procedure that was reviewed by the RUC and the Practice Expense Subcommittee at the February of 2011 RUC meeting. 33980 is a procedure that is performed in the facility setting 100% of the time and requires office staff time that would be typical of a 90-day global procedure performed in the facility setting.

The TAVR codes represent procedures that are performed in the facility 100% of the time under general anesthesia and require office staff time that would be typical for a 90-day global procedure performed in the facility setting. The main difference between the TAVR codes and the reference code is that the TAVR codes will be done jointly with the cardiologist and cardiovascular surgeon and requires additional scheduling and coordination of services because the cardiology office and the cardiovascular surgery office must both coordinate with the other specialists involved in the procedure which at a minimum include radiology, perfusionist and a specialized anesthesiologist. In addition, the procedure requires a hybrid OR room requiring special equipment for the catheter-based, surgical, and imaging aspects of the procedure and the cardiopulmonary bypass equipment all of which must be ordered and coordinated by each physician's clinical staff. . Since the codes were jointly surveyed involving cardiology and cardiac surgeons, the specialty societies are recommending CMS Code L037D with a blended staff type of RN/ LP/ MTA rather than the RN staff type typical to the cardiothoracic surgery codes.

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities: The clinical staff from both offices complete pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility. They will also coordinate with specialized anesthesiologist, the perfusionist, radiology and any other physician offices to set up the case. The clinical staff will also coordinate with the hospital to schedule the OR and the specialized equipment for the procedure. The operating room coordinating requires ensuring the needed hybrid equipment including the catheter-based equipment for the valve deployment, any instrumentation needed for an open approach or conversion to an open approach and cardiopulmonary bypass equipment as well as supporting imaging equipment for the procedure. The clinical staff will educate the patient on what they need to do to prepare for surgery. The staff ensures the patient and family fully understands the procedure and the recovery afterwards and obtains the operative consent. They make follow-up phone calls to the patient and the office of referring physicians and call in needed prescriptions.

CA002 (coordinate pre-surgery services): there are typically three physicians involved in a TAVR procedure, the cardiothoracic surgeon, an interventional cardiologist and an echocardiography physician who will perform the TEE which is separately billed. Additional specialists that are involved with TAVR include anesthesiologists, perfusionist and radiologists at a minimum. Additionally, pulmonary function testing and left heart catheterization may need to be arranged. Preoperative labs must be ordered and collated and imaging of the chest is often required to be scheduled prior to the procedure.

CA003 (schedule space and equipment in facility): In addition to coordinating all of the specialists involved, the specialized room and equipment must also be coordinated and scheduled. This involves ensuring that the hybrid OR suite and equipment are secured. Specialized equipment includes the catheter-based equipment for the valve deployment, instrumentation for conversion to an open approach, cardiopulmonary bypass equipment, the correct valve for the patient.

CA004 (provide education/obtain consent): The patient and their family will be educated and provide consent to both the cardiothoracic surgeon and the interventional cardiologist for this procedure. The staff from each office will meet with the patient and family independently to provide education and obtain consent for the procedure. The education from each specialty is distinct with the interventional cardiologist staff providing education on the transcatheter approach and delivery of the valve and the cardiothoracic surgeons staff focusing on the open aspects of the procedure and any covering contingencies for conversion to an open procedure or the need for placing the patient on cardiopulmonary bypass in an emergent situation if necessary. The consent is obtained in a visit with the patient, it is not obtained over the phone.

CA005 (complete pre-procedure phone calls and prescriptions): The patient and family are reminded of the scheduled procedure, given last minute instructions for prep and reporting for the procedure

Intra-Service Clinical Labor Activities: n/a

Post-Service Clinical Labor Activities: n/a

	A	B	D	E	F	G	H	I	J	K	L	N	P	R	T	V
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**		**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**33980**		**33361**		**33361**		**33362**	**33362**	**33363**	**33363**	**33364**
3		***RUC Collaboration Website***				Removal of ventricular assist device, implantable intracorporeal, single ventricle		TAVR with prosthetic valve; percutaneous femoral artery approach		TAVR with prosthetic valve; percutaneous femoral artery approach		open femoral artery approach	open femoral artery approach	open axillary artery approach	open axillary artery approach	open iliac artery approach
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**											
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**														
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 22.20**	**$ -**	**$ 22.20**	**$ -**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**
12		**PRE-SERVICE PERIOD**														
13		**Start: Following visit when decision for surgery or procedure made**														
14	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		5		5		5	5	5	5	5	5
15	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		20		20		20	20	20	20	20	20
16	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		8		8		8	8	8	8	8	8
17	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37		20		20		20	20	20	20	20	20
18	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		7		7		7	7	7	7	7	7
19	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37											
20	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37											
21	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37											
27		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											
28		**End: When patient enters office/facility for surgery/procedure**														

	A	B	D	E	F	G	H	I	J	K	L	N	P	R	T	V
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**		**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**33980**		**33361**		**33361**		**33362**	**33362**	**33363**	**33363**	**33364**
3		***RUC Collaboration Website***				Removal of ventricular assist device, implantable intracorporeal, single ventricle		TAVR with prosthetic valve; percutaneous femoral artery approach		TAVR with prosthetic valve; percutaneous femoral artery approach		open femoral artery approach	open femoral artery approach	open axillary artery approach	open axillary artery approach	open iliac artery approach
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**											
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**														
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
29		**SERVICE PERIOD**														
30		**Start: When patient enters office/facility for surgery/procedure:**														
31		**Pre-Service (of service period)**														
32	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37											
33	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37											
34	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37											
35	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37											
36	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37											
37	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37											
38	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37											
39	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37											
40	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37											
46		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											
47		**Intra-service (of service period)**														
48	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	L037D	RN/LPN/MTA	0.37											
49	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)	L037D	RN/LPN/MTA	0.37											
50	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)	L037D	RN/LPN/MTA	0.37											
51	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37											
57		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											

	A	B	D	E	F	G	H	I	J	K	L	N	P	R	T	V
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**		**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**33980**		**33361**		**33361**		**33362**	**33362**	**33363**	**33363**	**33364**
3		***RUC Collaboration Website***				Removal of ventricular assist device, implantable intracorporeal, single ventricle		TAVR with prosthetic valve; percutaneous femoral artery approach		TAVR with prosthetic valve; percutaneous femoral artery approach		open femoral artery approach	open femoral artery approach	open axillary artery approach	open axillary artery approach	open iliac artery approach
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**											
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**														
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
58		**Post-Service (of service period)**														
59	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37											
60	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37											
61	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37											
62	CA025	Clean scope	L037D	RN/LPN/MTA	0.37											
63	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37											
64	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37											
65	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37											
66	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37											
67	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L037D	RN/LPN/MTA	0.37											
68	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37											
69	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	L037D	RN/LPN/MTA	0.37											
70	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37											
71	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L037D	RN/LPN/MTA	0.37											
72	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37											
73	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**						
77		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											
78		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											
79		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											
80		**End: Patient leaves office**														

	A	B	D	E	F	G	H	I	J	K	L	N	P	R	T	V
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**		**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**33980**		**33361**		**33361**		**33362**	**33362**	**33363**	**33363**	**33364**
3		***RUC Collaboration Website***				Removal of ventricular assist device, implantable intracorporeal, single ventricle		TAVR with prosthetic valve; percutaneous femoral artery approach		TAVR with prosthetic valve; percutaneous femoral artery approach		open femoral artery approach	open femoral artery approach	open axillary artery approach	open axillary artery approach	open iliac artery approach
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**											
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**														
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
81		**POST-SERVICE PERIOD**														
82		**Start: Patient leaves office/facility**														
83	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37											
84	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37											
85		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
86		99211 16 minutes	16													
87		99212 27 minutes	27													
88		99213 36 minutes	36													
89		99214 53 minutes	53													
90		99215 63 minutes	63													
91	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											
96		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											
97		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37											
98		**End: with last office visit before end of global period**														

	A	B	D	E	F	G	H	I	J	K	L	N	P	R	T	V
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**		**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**33980**		**33361**		**33361**		**33362**	**33362**	**33363**	**33363**	**33364**
3		***RUC Collaboration Website***				Removal of ventricular assist device, implantable intracorporeal, single ventricle		TAVR with prosthetic valve; percutaneous femoral artery approach		TAVR with prosthetic valve; percutaneous femoral artery approach		open femoral artery approach	open femoral artery approach	open axillary artery approach	open axillary artery approach	open iliac artery approach
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**											
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**														
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
99	**Medical Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**												
100		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
101	SA048	pack, minimum multi-specialty visit	1.143	pack												
107		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*														
109	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**											
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
111	EF023	table, exam	1338.17		0.002976617											
117		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*														

	A	B	X	Z	AB	AD	AF
1	**RUC Practice Expense Spreadsheet**		**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**33364**	**33365**	**33365**	**33366**	**33366**
3		***RUC Collaboration Website***					
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	open iliac artery approach	transaortic approach (eg, median sternotom	transaortic approach (eg, median sternotom	transapical approach (eg, left thoracoto	transapical approach (eg, left thoracotomy)
5		**LOCATION**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**					
7		**TOTAL CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**	**$ 22.20**
12		**PRE-SERVICE PERIOD**					
13		**Start: Following visit when decision for surgery or procedure made**					
14	CA001	Complete pre-service diagnostic and referral forms	5	5	5	5	5
15	CA002	Coordinate pre-surgery services (including test results)	20	20	20	20	20
16	CA003	Schedule space and equipment in facility	8	8	8	8	8
17	CA004	Provide pre-service education/obtain consent	20	20	20	20	20
18	CA005	Complete pre-procedure phone calls and prescription	7	7	7	7	7
19	CA006	Confirm availability of prior images/studies					
20	CA007	Review patient clinical extant information and questionnaire					
21	CA008	Perform regulatory mandated quality assurance activity (pre-service)					
27		*Other activity: please include short clinical description here and type new in column A*					
28		**End: When patient enters office/facility for surgery/procedure**					

	A	B	X	Z	AB	AD	AF
1	**RUC Practice Expense Spreadsheet**		**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**33364**	**33365**	**33365**	**33366**	**33366**
3		***RUC Collaboration Website***					
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	open iliac artery approach	transaortic approach (eg, median sternotom	transaortic approach (eg, median sternotom	transapical approach (eg, left thoracoto	transapical approach (eg, left thoracotomy)
5		**LOCATION**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**					
7		**TOTAL CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
29		**SERVICE PERIOD**					
30		**Start: When patient enters office/facility for surgery/procedure:**					
31		**Pre-Service (of service period)**					
32	CA009	Greet patient, provide gowning, ensure appropriate medical records are available					
33	CA010	Obtain vital signs					
34	CA011	Provide education/obtain consent					
35	CA012	Review requisition, assess for special needs					
36	CA013	Prepare room, equipment and supplies					
37	CA014	Confirm order, protocol exam					
38	CA015	Setup scope (nonfacility setting only)					
39	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient					
40	CA017	Sedate/apply anesthesia					
46		*Other activity: please include short clinical description here and type new in column A*					
47		**Intra-service (of service period)**					
48	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)					
49	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)					
50	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)					
51	CA021	Perform procedure/service---NOT directly related to physician work time					
57		*Other activity: please include short clinical description here and type new in column A*					

	A	B	X	Z	AB	AD	AF
1	**RUC Practice Expense Spreadsheet**		**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**33364**	**33365**	**33365**	**33366**	**33366**
3		***RUC Collaboration Website***					
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	open iliac artery approach	transaortic approach (eg, median sternotom	transaortic approach (eg, median sternotom	transapical approach (eg, left thoracoto	transapical approach (eg, left thoracotomy)
5		**LOCATION**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**					
7		**TOTAL CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
58		**Post-Service (of service period)**					
59	CA022	Monitor patient following procedure/service, multitasking 1:4					
60	CA023	Monitor patient following procedure/service, no multitasking					
61	CA024	Clean room/equipment by clinical staff					
62	CA025	Clean scope					
63	CA026	Clean surgical instrument package					
64	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions					
65	CA028	Review/read post-procedure x-ray, lab and pathology reports					
66	CA029	Check dressings, catheters, wounds					
67	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page					
68	CA031	Review examination with interpreting MD/DO					
69	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.					
70	CA033	Perform regulatory mandated quality assurance activity (service period)					
71	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)					
72	CA035	Review home care instructions, coordinate visits/prescriptions					
73	CA036	Discharge day management					
77		*Other activity: please include short clinical description here and type new in column A*					
78		*Other activity: please include short clinical description here and type new in column A*					
79		*Other activity: please include short clinical description here and type new in column A*					
80		**End: Patient leaves office**					

	A	B	X	Z	AB	AD	AF
1	**RUC Practice Expense Spreadsheet**		**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**33364**	**33365**	**33365**	**33366**	**33366**
3		***RUC Collaboration Website***					
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	open iliac artery approach	transaortic approach (eg, median sternotom	transaortic approach (eg, median sternotom	transapical approach (eg, left thoracoto	transapical approach (eg, left thoracotomy)
5		**LOCATION**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**					
7		**TOTAL CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
81		**POST-SERVICE PERIOD**					
82		**Start: Patient leaves office/facility**					
83	CA037	Conduct patient communications					
84	CA038	Coordinate post-procedure services					
85		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
86		99211 16 minutes					
87		99212 27 minutes					
88		99213 36 minutes					
89		99214 53 minutes					
90		99215 63 minutes					
91	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95		*Other activity: please include short clinical description here and type new in column A*					
96		*Other activity: please include short clinical description here and type new in column A*					
97		*Other activity: please include short clinical description here and type new in column A*					
98		**End: with last office visit before end of global period**					

	A	B	X	Z	AB	AD	AF
1	**RUC Practice Expense Spreadsheet**		**COMMEND**	**CURRENT**	**COMMEND**	**CURRENT**	**COMMEND**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**33364**	**33365**	**33365**	**33366**	**33366**
3		***RUC Collaboration Website***					
4	**Clinical Activity Code**	**Meeting Date: October 2017 Tab: 11 Specialty: STS, ACC, SCAI, AATS**	open iliac artery approach	transaortic approach (eg, median sternotom	transaortic approach (eg, median sternotom	transapical approach (eg, left thoracoto	transapical approach (eg, left thoracotomy)
5		**LOCATION**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
6		**GLOBAL PERIOD**					
7		**TOTAL CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**60.0**	**60.0**	**60.0**	**60.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
99	**Medical Supply Code**	**MEDICAL SUPPLIES**					
100		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
101	SA048	pack, minimum multi-specialty visit					
107		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*					
109	**Equipment Code**	**EQUIPMENT**					
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
111	EF023	table, exam					
117		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*					

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2012

Transcatheter Aortic Valve Replacement

In February 2012, the CPT Editorial Panel deleted four Category III code (0256T-0259T) and approved nine codes to report transcatheter aortic valve replacement procedures.

The RUC thoroughly discussed the unique nature of these services to understand and assign the appropriate valuation for these services. First, the members noted these services require two physicians, an interventional cardiologist and a cardiothoracic surgeon, be actively working on the patient during these procedures. Each operator has distinctly required work, which are specific to the operator's skill set, and are not duplicative between the two. For these reasons, the CMS National Coverage Determination (NCD) mandates that two physicians be present for this procedure to be completed. Second, the RUC recognized the intense nature of these procedures. Patients eligible for these procedures have previously been turned down for aortic valve replacement surgery and are receiving these procedures as a last resort. The NCD further mandates this patient population and there are currently no indications that these procedure will be approved for otherwise operable patients in the future. Finally, the RUC noted that the recommendations made by the Committee will value the total work of the service. Physician time includes the clock time of the procedure and does not constitute the addition of each physician's time. Payment policy issues, related to the co-surgery modifier and resulting payment modifications, were not determined, as it is outside the purview of the RUC. The RUC understands that CMS will consider these issues.

Prior to surveying, the specialty societies obtained approval from the Research Subcommittee to conduct an alternative methodology for surveying these services. To ensure the complete work of both physicians was captured, each survey was conducted concurrently by a thoracic surgeon and an interventional cardiologist.

33361 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach***
The RUC reviewed the survey data from 33 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 135 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. The RUC agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 29.50, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33361 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33361, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC conducted the following methodology to ensure the recommended work value is relative to similar services. The Committee took CPT code 92986 *Percutaneous balloon valvuloplasty; aortic valve* (work RVU= 22.85, intra-service time= 113 minutes) and backed out the post-operative visits (remaining work RVU= 17.90) to ensure the comparison is based on a 000 day global equivalent. The difference between the two intra-service times (22 minutes) was multiplied by the IWPUT (0.16) and came to a value of 3.52. The value of 3.52 and 4.50 (the work RVU of 99291) were added to the base 17.90 work RVU of the balloon valvuloplasty code to arrive at a value of 25.92. The committee recognized that the surveyed code 33361 is a much more intense and complicated procedure compared to the balloon valvuloplasty service. **The RUC recommends a work RVU of 29.50 for CPT code 33361.**

33362 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach***
The RUC reviewed the survey data from 38 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 150 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 32.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33362 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33362, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC reviewed 33362 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 2.50 and increased time of 15 minutes. **The RUC recommends a work RVU of 32.00 for CPT code 33362.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

33363 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach***
The RUC reviewed the survey data from 33 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 33.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33363 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33363, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC reviewed 33363 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 3.50 and increased time of 45 minutes. **The RUC recommends a work RVU of 33.00 for CPT code 33363.**

33364 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach***
The RUC reviewed the survey data from 31 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 34.87, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33364 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33364, as described above, is a unique

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 33364 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 5.37 and increased time of 45 minutes. The RUC noted that while 33364 and 33363 have the same intra-service times, 33364 is a more intense procedure due to the transplant incision and longer closure times. **The RUC recommends a work RVU of 34.87 for CPT code 33364.**

33365 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)***
The RUC reviewed the survey data from 30 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 37.50, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle* (work RVU= 37.50) and agreed that while 33979 has more intra-service time compared to the surveyed code, both services should be valued similarly given that 33365 is a more intense procedure, as seen in the intensity complexity measures. The RUC also reviewed CPT code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33365 is a much more intense procedure. In addition, 33365, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 33365 in comparison to 33361 and agreed that the increase complexity was accurately reflected with the increase work RVU of 8.00 and increased time of 45 minutes. The RUC noted that while 33365 and 33364 have the same intra-service times, 33364 is a more intense procedure due to complexities opening the chest via median sternotomy. **The RUC recommends a work RVU of 37.50 for CPT code 33365.**

0318T ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)***
The RUC reviewed the survey data from 31 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 195 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 40.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle* (work RVU= 37.50) and agreed that while 33979 has more intra-service time compared to the surveyed code, 0318T should be valued slightly higher due to greater intensity, as seen in the intensity complexity measures. The RUC also reviewed CPT code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 0318T is a much more intense procedure. In addition, 0318T, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 0318T in comparison to 33361 and agreed that the increase complexity was accurately reflected with the increase work RVU of 10.50 and increased time of 60 minutes. **The RUC recommends a work RVU of 40.00 for CPT code 0318T.**

Add-On Services
The RUC noted that the three add-on cardiopulmonary bypass support services (33367-X9) are only reported by the thoracic surgeon and not performed by two physicians. These procedures are performed during standard transcatheter aortic valve replacement services upon the patient becoming hemodynamically unstable and cannot be stabilized by any standard medical means.

33367 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)***
The RUC reviewed the survey results from 35 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 90 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 11.88 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC reviewed the key reference code 37223 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 4.25) and agreed that the surveyed code has double the intra-service time and is a more intense procedure. Given this, 33367 should be valued much higher. In addition, CPT code 22845 *Anterior instrumentation; 2 to 3 vertebral segments* (work RVU= 11.94) was compared to 33367 and the RUC noted that the two services have identical intra-service time, 90 minutes, with comparable physician work, and should be valued similarly. **The RUC recommends a work RVU of 11.88 for CPT code 33367.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

33368 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)***
The RUC reviewed the survey results from 34 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 120 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 14.39 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC reviewed the key reference code 33960 *Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day* (work RVU= 10.59, valued as a ZZZ global service) and agreed that while the reference code has slightly greater intra-service time, 13 minutes, compared to 33368, the surveyed code is a more intense procedure and should be valued higher. In addition, the RUC reviewed CPT code 22843 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments* (work RVU= 13.44, intra-time= 120 minutes) and agreed that with identical intra-service time the surveyed code should be valued slightly higher due to greater intensity. **The RUC recommends a work RVU of 14.39 for CPT code 33368.**

33369 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)***
The RUC reviewed the survey results from 35 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 160 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 19.00 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC reviewed the key reference code 33305 Repair of cardiac wound; with cardiopulmonary bypass (work RVU= 29.60, valued as a ZZZ global period) and agreed that while the surveyed code is a more intense procedure, the reference code should be valued higher due to greater intra-service time, 296 minutes compared to 160 minutes. In addition, the RUC reviewed CPT code 22844 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments* (work RVU= 16.42, intra-service time= 150 minutes) and agreed that since the surveyed code has greater intra-service time and a higher intensity the value should be higher for 33369. **The RUC recommends a work RVU of 19.00 for CPT code 33369.**

Practice Expense: The TAVR codes represent procedures that will be performed in the facility 100% of the time and will require office staff time that would be typical for a 90-day global procedure performed in the facility setting. The TAVR codes will be done jointly with the cardiologist and cardiovascular surgeon and requires additional scheduling and coordination of services because the cardiology office and the cardiovascular surgery office must both coordinate with the other specialists involved in the procedure which at a minimum include radiology, perfusionist and a specialized anesthesiologist. In addition the procedure requires a hybrid OR room requiring special equipment for the catheter-based, surgical, and imaging aspects of the procedure and the cardiopulmonary bypass equipment. Since the codes were jointly surveyed involving cardiology and cardiac surgeons, the specialty societies are recommending CMS Code L037D with a blended staff type of RN/ LP/ MTA rather then the RN staff type typical to the cardiothoracic surgery codes. The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

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

RUC Database: These services will be flagged in the RUC database so they are not used to validate the physician work of other services in the RBRVS.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Codes 33361-33365, 0318T are used to report transcatheter aortic valve replacement (TAVR)/transcatheter aortic valve implantation (TAVI). TAVR/TAVI requires two physician operators and all components of the procedure are coded using modifier 62.

Codes 33361–33365, 0318T include the work, when performed, of percutaneous access, placing the access sheath, balloon aortic valvuloplasty, advancing the valve delivery system into position, repositioning the valve as needed, deploying the valve, temporary pacemaker insertion for rapid pacing (33210), and closure of the arteriotomy when performed. Codes 33362–33365, 0318T also include open arterial or cardiac approach.

Angiography, radiological supervision, and interpretation performed to guide TAVR/TAVI (eg, guiding valve placement, documenting completion of the intervention, assessing the vascular access site for closure) are included in these codes.

Diagnostic left heart catheterization codes (93452, 93453, 93458-93461) and the supravalvular aortography code (93567) should ~~NOT~~ **not** be used with TAVR/TAVI services (33361-33365, 0318T) to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TAVR/TAVI,
2. Aorta/left ventricular outflow tract measurement for the TAVR/TAVI, or
3. Post-TAVR/TAVI aortic or left ventricular angiography, as this work is captured in the TAVR/TAVI services codes (33361-33365, 0318T).

Diagnostic coronary angiography performed at the time of TAVR/TAVI may be separately reportable if:

1. No prior catheter-based coronary angiography study is available and a full diagnostic study is performed, OR
2. A prior study is available, but as documented in the medical record:
    a. The patient's condition with respect to the clinical indication has changed since the prior study, OR
    b. There is inadequate visualization of the anatomy and/or pathology, OR
    c. There is a clinical change during the procedure that requires new evaluation.
    d. For same session/same day diagnostic coronary angiography services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 indicating separate and distinct procedural service from TAVR/TAVI

Other cardiac catheterization services are reported separately when performed for diagnostic purposes not intrinsic to TAVR/TAVI.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Percutaneous coronary interventional procedures are reported separately, when performed.

When transcatheter ventricular support is required in conjunction with TAVR/TAVI, the appropriate code should be reported with the appropriate ventricular assist device (VAD) procedure code (33990-33993, 33975, 33976, 33999) or balloon pump insertion code (33967, 33970, 33973)

The TAVR/TAVI cardiovascular access and delivery procedures are reported with 33361-33365, 0318T. When cardiopulmonary bypass is performed in conjunction with TAVR/TAVI, codes 33361-33365, 0318T should be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369)

●33361	GG1	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	000	29.50
●33362	GG2	open femoral artery approach	000	32.00
●33363	GG3	open axillary artery approach	000	33.00
●33364	GG4	open iliac artery approach	000	34.87
●33365	GG5	transaortic approach (eg, median sternotomy, mediastinotomy)	000	37.50

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

●0318T	GG6	transapical approach (eg, left thoracotomy) (For percutaneous femoral artery, open femoral artery, open axillary artery, open iliac artery, or transaortic approach, see 33361-33365) (When cardiopulmonary bypass is used with code 0318T, report with the appropriate add-on code +33367, +33368, or +33369)	000	40.00
●+33367	GG7	cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure) (Use 33367 in conjunction with 33361-33366) (Do not report 33367 in conjunction with 33368 or 33369)	ZZZ	11.88
●+33368	GG8	cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure) (Use 33368 in conjunction with 33361-33366) (Do not report 33368 in conjunction with 33367,33369)	ZZZ	14.39
●+33369	GG9	cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure) (Use 33369 in conjunction with 33361-33366) (Do not report 33369 in conjunction with 33367, 33368)	ZZZ	19.00
D0256T		~~Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach~~	YYY	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

D0257T		~~Implantation of catheter-delivered prosthetic aortic heart valve; open thoracic approach (eg, transapical, transventricular)~~	YYY	N/A
D0258T		~~Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass~~	YYY	N/A
D0259T		~~Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass~~	YYY	N/A
(0256T has been deleted. To report, see 33361-33364) (0257T has been deleted. To report, see 33365, 0318T) (0258T has been deleted. To report, see 33365, 0318T) (0259T has been deleted. To report, see 33365-33369, 0318T)				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33367 Tracking Number GG7 Original Specialty Recommended RVU: **11.88**
Presented Recommended RVU: **11.88**
Global Period: ZZZ RUC Recommended RVU: **11.88**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)
(Use 33367 in conjunction with 33361-33366)
(Do not report 33367 in conjunction with 33368 or 33369)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. Note: This is an add-on service to the TAVR/TAVI which is reported separately.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: A patient undergoing TAVR becomes hemodynamically unstable, and cannot be stabilized with inotropic support or any standard medical means. The patient is anticoagulated. The artery and vein are cannulated with sheaths using direct percutaneous access. Guidewires are advanced into the distal abdominal aorta and into the superior vena cava. Dilators are employed to ultimately place a sufficient sized arterial cannula and a multiply ported venous drainage cannula across the right atrium into the superior vena cava. The cannulas are de-aired and connected to a cardiopulmonary bypass circuit. Cardiopulmonary bypass is initiated. Cardiopulmonary bypass with its attendant volume shifts and the activation of the inflammatory system is managed with volume replacement and alpha effector agents. Anticoagulation is maintained. Management continues while the TAVR procedure is completed. The patient's temperature, hematocrit, pH, level of oxygenation and electrolytes are normalized and the patient is weaned from cardiopulmonary bypass. Anticoagulation is reversed. The cannulas are removed percutaneously. Hemostasis is achieved through percutaneous closure devices or, if necessary, open vascular repair (reported separately).

CPT Code: 33367

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC		
CPT Code:	33367		
Sample Size:	70	**Resp N:** 35	**Response:** 50.0 %
Description of Sample:	Targeted. As approved by the Research subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	5.00	28.00
Survey RVW:	5.00	11.88	**16.67**	26.20	100.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	45.00	**90.00**	180.00	360.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	33367	**Recommended Physician Work RVU: 11.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37223	ZZZ	4.25	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1 see separate MPC table for TAVR codes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33960	ZZZ	10.59	**RUC Time**

CPT Descriptor Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours
*CPT code is a 000 day global that was adjusted in work and time to represent a ZZZ global per approval from the research subcommittee and the adjusted time data was used on the RSL.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 33367**	**Key Reference CPT Code:** 37223	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	90.00	45.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**90.00**	**45.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.29	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.71
Urgency of medical decision making	4.57	3.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.29	4.00
Physical effort required	3.43	3.43
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.57	3.43
Outcome depends on the skill and judgment of physician	4.71	3.43
Estimated risk of malpractice suit with poor outcome	4.29	3.43

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.29	3.14
Intra-Service intensity/complexity	3.71	3.57
Post-Service intensity/complexity	4.00	3.14

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were the cardiac surgeon members of teams of co-operators who participated in clinical trials of these new devices.

They evaluated the three add-on, ZZZ codes to report when cardiopulmonary bypass is necessary for the procedure (**33367**, **33368**, **33369**).

The three bypass codes represent different approaches for accomplishing bypass if it becomes necessary during the procedure. The majority of TAVR cases that require bypass will involve an emergent situation that occurs during the procedure due to aortic insufficiency or the patient's inability to withstand rapid pacing or balloon valvuloplasty. There will be a small percentage of cases where bypass is planned as part of the procedure and it will only be applicable to a specific patient population and will not be typical.

The three cardiopulmonary bypass codes were surveyed specifically as they relate to the TAVR procedures. Bypass related to TAVR is not equivalent to any of the existing "with or without" bypass procedure. In addition, the typical TAVR patient is 83 years old with multiple comorbidities, adding to the complexity of the procedure.

The Expert Panel reviewed the survey results and recommends that the 25th percentile RVWs for these codes accurately represents the work involved and results in an appropriate IWPUT (0.132) for this service. This intensity is well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including several codes from the current MPC list. This intensity is frequently observed in add-on codes, and accurately reflects the significant urgent decision making which must be made to select appropriate vascular access sites and accomplish the technical aspects of the procedure in patients with significant diffuse vascular disease. Management of cardiopulmonary bypass and the inherent bleeding risk and inflammatory while continuing the valve replacement procedure adds significant work to the base procedure.

In the context of the entire presentation of **33361**-**33369**, it is important to note that the -62 modifier would not be appended to the codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your

scenario. Code 33367 will be reported in conjunction with one of the new codes 33361- 33366 when applicable.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0259T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 75
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, of that number it is estimated that approximately 5% will require emergent cardiopulmonary bypas support. There are three bypass codes and it is estimated that the 33367 percutaneouls peripheraial approach will be utilized 30% of the time, that 33368 open peripherial approach will be utilized 30% of the time and that 33369 central access will be used 40% of the time.

Specialty Cardiovascular Surgery Frequency 75 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 71 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiovascular Surgery Frequency 71 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? No

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33979

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33368 Tracking Number GG8 Original Specialty Recommended RVU: **14.39**
Presented Recommended RVU: **14.39**
Global Period: ZZZ RUC Recommended RVU: **14.39**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)
(Use 33368 in conjunction with 33361-33366)
(Do not report 33368 in conjunction with 33367 or 33369)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. However, the femoral vessels are not suitable for percutaneous cannulation, therefore an open approach is utilized. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. Note: This is an add-on service to the TAVR/TAVI which is reported separately.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: A patient undergoing TAVR becomes hemodynamically unstable, and cannot be stabilized with inotropic support or any standard medical means. The patient is anticoagulated. A new incision is made and the artery and vein are exposed and controlled with vessel loops. The artery is clamped and a transverse arteriotomy performed. A suitably sized arterial cannula is advanced over a guidewire. A pursestring polypropylene suture is place in the vein, and a guidewire inserted through a needle placed within it and advanced into the vena cava under fluoroscopic guidance. A multiply ported venous drainage cannula is passed over the guidewire, across the right atrium and into the vena cava. The cannulas are de-aired and connected to a cardiopulmonary bypass circuit. Cardiopulmonary bypass is initiated. Cardiopulmonary bypass with its attendant volume shifts and the activation of the inflammatory system is managed with volume replacement and alpha effector agents. Anticoagulation is maintained. Management continues while the TAVR procedure is completed. The patient's temperature, hematocrit, pH, level of oxygenation and electrolytes are

normalized and the patient is weaned from cardiopulmonary bypass. The venous cannula is removed and bleeding controlled by tying the previously placed pursestring. The arterial cannula is removed and the arteriotomy is repaired with 6-0 polypropylene sutures. Anticoagulation is reversed, and after assuring hemostasis the wound is closed in layers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC		
CPT Code:	33368		
Sample Size:	70	**Resp N:** 34	**Response:** 48.5 %
Description of Sample:	Targeted. As approved by the Research subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	5.00	125.00
Survey RVW:	8.25	14.39	**20.00**	28.63	110.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	74.00	**120.00**	180.00	400.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	33368	**Recommended Physician Work RVU: 14.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**120.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33960	ZZZ	10.59	**RUC Time**

CPT Descriptor Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day
*code value was adjusted to ZZZ global from 000 day global for RSL which was approved by the Research Subcommittee

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1 see separate MPC table for TAVR codes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33426	ZZZ	22.75	**RUC Time**

CPT Descriptor Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring
*code value was adjusted to ZZZ global from 090 day global for RSL which was approved by the Research Subcommittee

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 33368**	**Key Reference CPT Code:** 33960	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	120.00	133.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**120.00**	**133.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.57	4.14
Urgency of medical decision making	4.71	4.57
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.29	4.14
Physical effort required	4.00	4.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.71	4.29
Outcome depends on the skill and judgment of physician	4.57	4.29
Estimated risk of malpractice suit with poor outcome	4.00	3.71

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	3.57
Intra-Service intensity/complexity	4.43	4.00
Post-Service intensity/complexity	4.14	4.43

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and finalize the recommendations. The survey response rate was excellent and the results were internally

consistent. All survey respondents were the cardiac surgeon members of teams of co-operators who participated in clinical trials of these new devices.

They evaluated the three add-on, ZZZ codes to report when cardiopulmonary bypass is necessary for the procedure (33367, 33368, 33369).

The three bypass codes represent different approaches for accomplishing bypass if it becomes necessary during the procedure. The majority of TAVR cases that require bypass will involve an emergent situation that occurs during the procedure due to aortic insufficiency or the patient's inability to withstand rapid pacing or balloon valvuloplasty. There will be a small percentage of cases where bypass is planned as part of the procedure and it will only be applicable to a specific patient population and will not be typical.

The three cardiopulmonary bypass codes were surveyed specifically as they relate to the TAVR procedures. Bypass related to TAVR is not equivalent to any of the existing "with or without" bypass procedure. In addition, the typical TAVR patient is 83 years old with multiple comorbidities, adding to the complexity of the procedure.

The Expert Panel reviewed the survey results and recommends that the 25th percentile RVWs for these codes accurately represents the work involved and results in an appropriate IWPUT (0.120) for this service. This intensity is well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including several codes from the current MPC list. This intensity is frequently observed in add-on codes, and accurately reflects the significant urgent decision making which must be made to select appropriate vascular access sites and accomplish the technical aspects of the procedure in patients with significant diffuse vascular disease. Management of cardiopulmonary bypass and the inherent increased bleeding and inflammatory response as well as operative repair of the cannulation sites (not billed separately) adds significant work to the base procedure.

In the context of the entire presentation of 33361-33369, it is important to note that the -62 modifier would not be appended to the codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Code 33368 will be reported in conjunction with one of the new codes 33361-33367 when applicable

---

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0259T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 75
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, of that number it is estimated that approximately 5% will require emergent cardiopulmonary bypas support. There are three bypass codes and it is estimated that the 33367 percutaneouls peripheraial approach will be utilized 30% of the time, that 33368 open peripherial approach will be utilized 30% of the time and that 33369 central access will be used 40% of the time.

Specialty Cardiovascular Surgery Frequency 75 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 71 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiovascular Surgery Frequency 71 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33979

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33369 Tracking Number GG9 Original Specialty Recommended RVU: **19.00**
Presented Recommended RVU: **19.00**
Global Period: ZZZ RUC Recommended RVU: **19.00**

CPT Descriptor: Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)
(Use 33369 in conjunction with 33361-33366)
(Do not report 33369 in conjunction with 33367 or 33368)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83 y/o male with aortic stenosis, coronary artery disease, and Class III-IV heart failure. The aortic stenosis is life-limiting and severely symptomatic, and is characterized as critical with a documented aortic valve orifice area of 0.6 cm2. He has multiple additional co-morbidities that make his risk of mortality with conventional open heart aortic valve replacement greater than 10% by objective predictive criteria. He is evaluated by the valve-team comprised of a cardiac surgeon and an interventional cardiologist who agree that the operative risks outweigh the benefit. The team therefore recommends transcatheter aortic valve replacement. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. However, because of severe aortoiliac disease, central arterial and venous access is required for institution of safe cardiopulmonary bypass. In the course of the procedure, the patient becomes unstable and full extracorporeal cardiopulmonary support is required. Note: This is an add-on service to the TAVR/TAVI which is reported separately.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 6%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 6%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: A patient undergoing TAVR becomes hemodynamically unstable, and cannot be stabilized with inotropic support or any standard medical means. The patient is anticoagulated. If not already achieved by the TAVR approach, exposure of the great vessels is obtained by rapid median sternotomy and the creation of a pericardial well. The aorta is directly cannulated for arterial inflow and a dual stage venous return cannula is placed through a right atrial incision. Cardiopulmonary bypass is initiated. Pursestrings are then placed about both cannulae and they are secured. Cardiopulmonary bypass with its attendant volume shifts and the activation of the inflammatory system is managed with volume replacement and alpha effector agents. Anticoagulation is maintained. Management continues while the TAVR procedure is completed. The patient's temperature, hematocrit, pH, level of oxygenation and electrolytes are normalized and the patient is weaned from cardiopulmonary bypass. Anticoagulation is reversed, the cannulae removed and hemostasis is achieved by tying the previously placed pursestring sutures. Additional sutures may be required. After assuring

hemostasis, the sternum is reapproximated with stainless steel wires over mediastinal drains. The wound is then irrigated and closed in layers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2012		
Presenter(s):	Jim Levett, MD; Stephen Lahey, MD; Jeff Jacobs, MD; Richard Wright, MD; Clifford Kavinsky, MD		
Specialty(s):	STS, ACC		
CPT Code:	33369		
Sample Size:	70	**Resp N:** 35	**Response:** 50.0 %
Description of Sample:	Targeted. As approved by the Research subcommittee, the STS and ACC sent the survey to physicians who participated in a TAVR trial. This sample represented 70 sites.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	5.00	100.00
Survey RVW:	10.00	19.00	**27.95**	32.88	120.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	90.00	**160.00**	240.00	420.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	33369	**Recommended Physician Work RVU: 19.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**160.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service?

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33305	ZZZ	29.60	**RUC Time**

CPT Descriptor Repair of cardiac wound; with cardiopulmonary bypass
*code value was adjusted to ZZZ global from 0900 day global for RSL which was approved by the Research Subcommittee

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1 see separate MPC table for TAVR codes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33530	ZZZ	8.08	**RUC Time**

CPT Descriptor Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 42.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 33369**	**Key Reference CPT Code:** 33305	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	160.00	296.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**160.00**	**296.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.87	4.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.87	4.27
Urgency of medical decision making	4.73	4.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.87	4.80
Physical effort required	4.47	4.40
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.87	4.33
Outcome depends on the skill and judgment of physician	4.73	4.33
Estimated risk of malpractice suit with poor outcome	4.20	3.87

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.80	4.40
Intra-Service intensity/complexity	4.87	4.33
Post-Service intensity/complexity	4.80	4.20

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An Expert Panel with representatives from the American College of Cardiology, Society of Thoracic Surgeons and the Society for Cardiac Angiography and Interventions was convened to review the survey results and

finalize the recommendations. The survey response rate was excellent and the results were internally consistent. All survey respondents were the cardiac surgeon members of teams of co-operators who participated in clinical trials of these new devices.

They evaluated the three add-on, ZZZ codes to report when cardiopulmonary bypass is necessary for the procedure (33367, 33368, 33369).

The three bypass codes represent different approaches for accomplishing bypass if it becomes necessary during the procedure. The majority of TAVR cases that require bypass will involve an emergent situation that occurs during the procedure due to aortic insufficiency or the patient's inability to withstand rapid pacing or balloon valvuloplasty. There will be a small percentage of cases where bypass is planned as part of the procedure and it will only be applicable to a specific patient population and will not be typical.

The three cardiopulmonary bypass codes were surveyed specifically as they relate to the TAVR procedures. Bypass related to TAVR is not equivalent to any of the existing "with or without" bypass procedure. In addition, the typical TAVR patient is 83 years old with multiple comorbidities, adding to the complexity of the procedure.

The Expert Panel reviewed the survey results and recommends that the 25th percentile RVWs for these codes accurately represents the work involved and results in an appropriate IWPUT (0.119) for this service. This intensity is well within the typical range for similar procedures provided by these and other specialties. A separate file has been provided for comparative review, including several codes from the current MPC list. This intensity is frequently observed in add-on codes, and accurately reflects the significant urgent decision making which must be made to select appropriate vascular access sites and accomplish the technical aspects of the procedure in patients with significant diffuse vascular disease. Management of cardiopulmonary bypass and the inherent increased bleeding and inflammatory response as well as operative repair of the cannulation sites (not billed separately) adds significant work to the base procedure.

In the context of the entire presentation of 33361-33369, it is important to note that the -62 modifier would not be appended to the codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Code 33369 will be reported in conjunction with one of the new codes 33361-33366 when applicable

---

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0259T Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiovascular Surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 5000 minimally invasive aortic valve implantation procedures will be performed per year, of that number it is estimated that approximately 5% will require emergent cardiopulmonary bypas support. There are three bypass codes and it is estimated that the 33367 percutaneouls peripheraial approach will be utilized 30% of the time, that 33368 open peripherial approach will be utilized 30% of the time and that 33369 central access will be used 40% of the time.

Specialty Cardiovascular Surgery Frequency 100 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 95 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 95% of the procedures will be performed on Medicare patients.

Specialty Cardiovascular Surgery Frequency 95 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33305

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
11	**ISSUE:**	**Transcatheter Aortic Valve Replcement**																									
12	**TAB:**	**12**																									
13	**000 Day Global codes**																										
14						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**FAC-inpt/same day**						
15	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**91**	**92**	**33**	**32**	**31**	**38**	**39**
16	**REF**	**33880**	**Endovascular repair of**	**14**	**0.096**			**27.21**			**455**	**90**	**20**	**20**			**225**			**45**			**1**				
18	**SVY**	**33361**	**Transcatheter aortic valve**	**33**	**0.165**	**6.74**	**25.13**	**29.50**	**35.00**	**50.00**	**345**	**45**	**20**	**30**	**30**	**120**	**135**	**180**	**300**	**45**	**1**						
19	**REC**	**33361**	**Transcatheter aortic valve**		**0.166**			**29.50**			**335**	**50**	**15**	**20**			**135**			**45**	**1**						
20	**62 modifier**	**33361**	**Transcatheter aortic valve**		**0.104**			**18.44**			**335**	**50**	**15**	**20**			**135**			**45**	**1**						
21																											
22	**REF**	**33880**	**Endovascular repair of**	**19**	**0.096**			**27.21**			**455**	**90**	**20**	**20**			**225**			**45**			**1**				
24	**SVY**	**33362**	**open femoral artery approach**	**38**	**0.165**	**11.34**	**27.52**	**32.00**	**35.59**	**54.00**	**360**	**45**	**20**	**30**	**30**	**120**	**150**	**195**	**300**	**45**	**1**						
25	**REC**	**33362**	**open femoral artery approach**		**0.166**			**32.00**			**350**	**50**	**15**	**20**			**150**			**45**	**1**						
26	**62 modifier**	**33362**	**open femoral artery approach**		**0.104**			**20.00**			**350**	**50**	**15**	**20**			**150**			**45**	**1**						
27																											
28	**REF**	**33880**	**Endovascular repair of**	**13**	**0.096**			**27.21**			**455**	**90**	**20**	**20**			**225**			**45**			**1**				
30	**SVY- 0 performance**	**33363**	**open axillary artery approach**	**17**	**0.132**	**11.34**	**28.13**	**31.50**	**39.25**	**58.00**	**415**	**60**	**30**	**30**	**120**	**135**	**180**	**195**	**330**	**45**	**1**						
31	**SVY >0 performance**	**33363**	**open axillary artery approach**	**16**	**0.151**	**22.21**	**29.25**	**33.50**	**37.50**	**51.11**	**391**	**53**	**20**	**30**	**70**	**135**	**173**	**240**	**250**	**45**	**1**						
32	**SVY- Aggregate**	**33363**	**open axillary artery approach**	**33**	**0.139**	**11.34**	**28.50**	**33.00**	**37.50**	**58.00**	**423**	**60**	**30**	**30**	**70**	**130**	**180**	**200**	**330**	**53**	**1**						
33	**REC**	**33363**	**open axillary artery approach**		**0.144**			**33.00**			**380**	**50**	**15**	**20**			**180**			**45**	**1**						
34	**62 modifier**	**33363**	**open axillary artery approach**		**0.090**			**20.63**			**380**	**50**	**15**	**20**			**180**			**45**	**1**						

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39
35																											
36	REF	33880	Endovascular repair of	15	0.096			27.21			455	90	20	20			225			45	1						
38	SVY	33364	open iliac artery approach	31	0.152	8.80	30.00	34.87	39.74	65.00	403	53	25	30	70	150	180	240	330	45	1						
39	REC	33364	open iliac artery approach		0.154			34.87			380	50	15	20			180			45	1						
40	62 modifier	33364	open iliac artery approach		0.096			21.79			380	50	15	20			180			45	1						
41																											
42	REF	33979	Insertion of ventricular assist	15	0.117			37.50			495	60	20	15			280			120							
44	SVY	33365	transaortic approach (eg,	30	0.165	10.50	30.00	37.50	40.00	56.00	415	60	30	30	45	175	180	210	340	45	1						
45	REC	33365	transaortic approach (eg,		0.169			37.50			380	50	15	20			180			45	1						
46	62 modifier	33365	transaortic approach (eg,		0.105			23.44			380	50	15	20			180			45	1						
47																											
48	REF	33979	Insertion of ventricular assist	18	0.117			37.50			495	60	20	15			280			120							
50	SVY- 0 performance	33366	transapical approach (eg, left	19	0.192	27.21	37.50	42.00	45.06	56.00	403	53	25	30	100	148	180	213	320	45	1						
51	SVY >0 performance	33366	transapical approach (eg, left	12	0.125	22.21	28.91	33.00	37.75	46.75	443	60	30	30	75	180	200	250	340	53	1						
52	SVY- Aggregate	33366	transapical approach (eg, left	31	0.165	22.21	32.00	40.00	43.13	56.00	430	60	30	30	75	173	195	225	340	45	1						
53	REC	33366	transapical approach (eg, left		0.169			40.00			395	50	15	20			195			45	1						
54	62 modifier	33366	transapical approach (eg, left		0.105			25.00			395	50	15	20			195			45	1						
55	Reference code RVW and times have been adjusted to represent 000 day global procedures as used in RSL for survey and approved by Research Subcommittee																										

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day						
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39
56																											
57	**ZZZ Day Global codes**																										
58	REF	37223	Revascularization, endovascular, open	7	0.094			4.21			45						45										
60	SVY	33367	Transcatheter aortic valve replacement	35	0.185	5.00	11.88	16.67	26.20	100.00	90				3	45	90	180	360								
61	REC	33367	Transcatheter aortic valve		0.132			11.88			90						90										
62																											
63	REF	33960	Prolonged extracorporeal	7	0.080			10.59			133						133										
65	SVY	33368	cardiopulmonary bypass support	34	0.167	8.25	14.39	20.00	28.63	110.00	120				4	74	120	180	400								
66	REC	33368	cardiopulmonary bypass support		0.120			14.39			120						120										
67																											
68	REF	33305	Repair of cardiac wound; with	15	0.100			29.60			296						296										
70	SVY	33369	cardiopulmonary bypass support	35	0.175	10.00	19.00	27.95	32.88	120.00	160				5	90	160	240	420								
71	REC	33369	cardiopulmonary bypass support		0.119			19.00			160						160										
72	**Reference code RVW and times have been adjusted to represent ZZZ global procedures as used in RSL for survey and approved by Research Subcommittee**																										
73																											
74																											

glob day	CPT code	MPC	Predominant Specialty	Long Descriptor	2012 IWPUT	ZZZ Work RVU	ZZZ Time	2012 Work RVU	RUC Year	Medicare Freq 2010	Dress scrub and wait time	pre service eval time	intra service time	other preop time (positioning)	same day post op time (immd post same day	Office Visits time	post op hosp time	Total time
ZZZ	63295	Yes	Neurosurgery	Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)	0.112	5.03	45	5.25	2004	40	0	10	45	0	0	0	0	55
000	31600	Yes	General Surgery	Tracheostomy, planned (separate procedure);	0.114	4.57	40	7.17	2000	37,809	0	50	40	0	66	0	0	156
ZZZ	61797	No	Neurosurgery	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)	0.116	3.48	30	3.48	2008	3,509	0	0	30	0	0	0	0	30
XXX	33982	No	Cardiothoracic Surgery	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	0.117	34.00	290	37.86	2010	3	20	60	290	15	90	0	0	475
ZZZ	33369		Cardiovascular Surgery	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary	0.119	19.00	160	19.00	Specialty Recommendations				160					160
000	36556	Yes	Anesthesiology	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	0.119	1.79	15	2.50	2003	516,697	5	15	15	5	10	0	0	50
000	37191	No	no data	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	0.120	3.59	30	4.71	2011	no data	5	30	30	3	15	0	0	83
ZZZ	33368		Cardiovascular Surgery	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)	0.120	14.39	120	14.39	Specialty Recommendations				120					120
000	52344	No	Urology	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg,	0.120	5.40	45	7.05	2010	2,654	10	40	45	10	20	0	0	125
ZZZ	35600	Yes	Cardiac Surgery	Harvest of upper extremity artery, 1 segment, for coronary artery bypass	0.124	4.94	40	4.94	2000	2,373	0	0	40	0	0	0	0	40
000	93581	No	Cardiology	Percutaneous transcatheter closure of a congenital ventricular septal defect with	0.124	22.37	180	24.39	2002	55	0	30	180	0	60	0	0	270
000	16035	No	Podiatry	Escharotomy; initial incision	0.131	2.62	20	3.74	2000	636	0	30	20	0	20	0	0	70

glob day	CPT code	MPC	Predominant Specialty	Long Descriptor	2012 IWPUT	ZZZ Work RVU	ZZZ Time	2012 Work RVU	RUC Year	Medicare Freq 2010	Dress scrub and wait time	pre service eval time	intra service time	other preop time (positioning)	same day post op time (immd post same day	Office Visits time	post op hosp time	Total time
ZZZ	33367		Cardiovascular Surgery	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)	0.132	11.88	90	11.88	Specialty Recommendations				90					90
ZZZ	33884	No	Vascular surgery	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)	0.137	8.20	60	8.20	2005	125	0	0	60	0	0	0	0	60

12, 13, 14, 36, 48
Tab Number

TAVR, PVAD, Cervicocerebral Angiography, Extremity Studies, CV Stress Tests
Issue

_3341X1-X9, 339XX1-XX4, 362XX1-XX8, 93935-6, 93970, 93015-18_
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)



Signature

Richard Wright, MD
Printed Signature

ACC
Specialty Society

4/2/12
Date

12
Tab Number

Transcatheter Aortic Valve Replacement
Issue

334X1 – 334X9
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)



Signature

James Levett, MD
Printed Signature

Society of Thoracic Surgeons
Specialty Society

April 2, 2012
Date

CPT Code: 33361 – 33366
Specialty Society('s): ACC/ STS/ SCAI

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

33361 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362 - open femoral artery approach
33363 - open axillary artery approach
33364 - open iliac artery approach
33365 - transaortic approach (eg, median sternotomy, mediastinotomy)
33366 - transapical approach (eg, left thoracotomy)

Global Period: 000 Meeting Date: April 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:

Codes 33980 - Removal of ventricular assist device, implantable intracorporeal, single ventricle
This code represents an XXX global procedure that was reviewed by the RUC and the Practice Expense Subcommittee at the February of 2011 RUC meeting. 33980 is a procedure that is performed in the facility setting 100% of the time and requires office staff time that would be typical of a 90-day global procedure performed in the facility setting. This code has an approved pre-facility clinical staff time of 60 minutes. Since cardiothoracic offices typically employ PAs, the cardiothoracic codes are typically assigned CMS code L051A and staff type RN.

The TAVR codes also represent procedures that will be performed in the facility 100% of the time and will require office staff time that would be typical for a 90-day global procedure performed in the facility setting. The main difference between the TAVR codes and the reference code is that the TAVR codes will be done jointly with the cardiologist and cardiovascular surgeon and requires additional scheduling and coordination of services because the cardiology office and the cardiovascular surgery office must both coordinate with the other specialists involved in the procedure which at a minimum include radiology, perfusionist and a specialized anesthesiologist. In addition the procedure requires a hybrid OR room requiring special equipment for the catheter-based, surgical, and imaging aspects of the procedure and the cardiopulmonary bypass equipment. Since the codes were jointly surveyed involving cardiology and cardiac surgeons, the specialty societies are recommending CMS Code L037D with a blended staff type of RN/ LP/ MTA rather then the RN staff type typical to the cardiothoracic surgery codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical staff from both offices fill out the pre-service diagnostic and referral forms. They call the hospital

to schedule space and equipment needed in the facility. They will also coordinate with specialized anesthesiologist, the perfusionist, radiology and any other physician offices to set up the case. The clinical staff will also coordinate with the hospital to schedule the OR and the specialized equipment for the procedure. The operating room coordinating requires ensuring the needed hybrid equipment including the catheter-based equipment for the valve deployment, any instrumentation needed for an open approach or conversion to an open approach and cardiopulmonary bypass equipment as well as supporting imaging equipment for the procedure. The clinical staff will educate the patient on what they need to do to prepare for surgery. The staff ensures the patient and family fully understands the procedure and the recovery afterwards and obtains the operative consent. They make follow-up phone calls to the patient and the office of referring physicians and call in needed prescriptions.

	A	B	C	D	E	F	G	H	I	J
1				Reference Code						
2				**33980**	**33361**	**33362**	**33363**	**33364**	**33365**	**33366**
3	**Meeting Date: April 2012** **Tab: 12** **Specialty: ACC/STS/SCAI**	**CMS Code**	**Staff Type**	Removal of ventricular assist device, impantable intracorporeal, single ventricle (CMS Code is L015A staff type is RN)	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	open femoral artery approach	open axillary artery approach	open iliac artery approach	transaortic approach (eg, median sternotomy, mediastinotomy)	transapical approach (eg, left thoracotomy)
4	**LOCATION**			**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LP/MTA	**60.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LP/MTA	**60.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**									
11	**Start: Following visit when decision for surgery or procedure made**									
12	Complete pre-service diagnostic & referral forms	L037D	RN/LP/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	L037D	RN/LP/MTA	**20**	**10**	**10**	**10**	**10**	**10**	**10**
14	Schedule space and equipment in facility	L037D	RN/LP/MTA	**8**	**5**	**5**	**5**	**5**	**5**	**5**
15	Provide pre-service education/obtain consent	L037D	RN/LP/MTA	**20**	**7**	**7**	**7**	**7**	**7**	**7**
16	Follow-up phone calls & prescriptions	L037D	RN/LP/MTA	**7**	**3**	**3**	**3**	**3**	**3**	**3**
17	Other Clinical Activity - *specify:*									
18	**End: When patient enters office/facility for surgery/procedure**									
19	**SERVICE PERIOD**									
43	**POST-SERVICE Period**									
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**							
62	**EQUIPMENT**	**CODE**								
63										
64										
65										
66										
67										

	A	B	C	D	E	F	G	H	I	J
1				Reference Code						
2				**33980**	**33361**	**33362**	**33363**	**33364**	**33365**	**33366**
3	**Meeting Date: April 2012** **Tab: 12** **Specialty: ACC/STS/SCAI**	**CMS Code**	**Staff Type**	Removal of ventricular assist device, impantable intracorporeal, single ventricle (CMS Code is L015A staff type is RN)	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	open femoral artery approach	open axillary artery approach	open iliac artery approach	transaortic approach (eg, median sternotomy, mediastinotomy)	transapical approach (eg, left thoracotomy)
4	**LOCATION**			**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**	**Facility**
5	**GLOBAL PERIOD**			**XXX**	**000**	**000**	**000**	**000**	**000**	**000**
6	**TOTAL CLINICAL LABOR TIME**	L037D	RN/LP/MTA	**60.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	L037D	RN/LP/MTA	**60.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**	**80.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**									
11	**Start: Following visit when decision for surgery or procedure made**									
12	Complete pre-service diagnostic & referral forms	L037D	RN/LP/MTA	**5**	**5**	**5**	**5**	**5**	**5**	**5**
13	Coordinate pre-surgery services	L037D	RN/LP/MTA	**20**	**40**	**40**	**40**	**40**	**40**	**40**
14	Schedule space and equipment in facility	L037D	RN/LP/MTA	**8**	**8**	**8**	**8**	**8**	**8**	**8**
15	Provide pre-service education/obtain consent	L037D	RN/LP/MTA	**20**	**20**	**20**	**20**	**20**	**20**	**20**
16	Follow-up phone calls & prescriptions	L037D	RN/LP/MTA	**7**	**7**	**7**	**7**	**7**	**7**	**7**
17	Other Clinical Activity - *specify:*									
18	**End: When patient enters office/facility for surgery/procedure**									
19	**SERVICE PERIOD**									
43	**POST-SERVICE Period**									
55	**MEDICAL SUPPLIES**	**CODE**	**UNIT**							
62	**EQUIPMENT**	**CODE**								
63										
64										
65										
66										
67										

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Endovascular Repair of Aortic Coarctation – Tab 8

In October 2020, the CPT Editorial Panel created two codes to report endovascular stent repair of coarctation of the thoracic or abdominal aorta and one code to report trans-liminal angioplasty for repair of native or recurrent percutaneous coarctation of the aorta.

33894 ***Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches***

The RUC reviewed the survey results from 41 interventional and pediatric interventional cardiologists and recommends 60 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 134 minutes of intra-service time and 60 minutes of immediate post-service time. The specialties noted that, unlike codes 33895 and 33897, the pre-service evaluation work for 33894 includes evaluation using a 3D-printed model of the heart which requires additional pre-service evaluation time. The specialties also noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The RUC reviewed both the survey 25th percentile work RVU of 18.27 and survey median work value of 23.30 and agreed that the appropriate value for this service should be between the 25th percentile and the median value. The RUC agreed that a direct work value crosswalk to CPT code 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU= 21.70, intra-service time of 135 minutes, total time of 223 minutes) and noted that both services involve nearly the same amount of intra-service time (134 minutes vs. 135 minutes) and the same overall amount of physician work. The RUC also compared the survey code to top key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180, total time of 270) and noted that the reference code involves more total time yet less intra-service time. The RUC also noted that 75 percent of the survey respondents that selected the top key reference code had rated the survey code as more intense and complex to perform. A value of 21.70, would appropriately value this survey code at a lower work value, yet somewhat higher intensity than the survey code, given the differences in intra-service time and intensity between the two services. **The RUC recommends a work RVU of 21.70 for CPT code 33894.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

33895 ***Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; not crossing major side branches***
The RUC reviewed the survey results from 41 interventional and pediatric interventional cardiologists and recommends 50 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time and 60 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The RUC reviewed both the survey 25th percentile work RVU of 15.00 and survey median work value of 20.00 and agreed that the appropriate value for this service should be between the 25th percentile and the median value. The RUC agreed that a direct work value crosswalk to CPT code 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU= 17.97, intra-service time of 120 minutes, total time of 208 minutes) and noted that both services involve an identical amount of intra-service time. The RUC also compared the survey code to second key reference code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, intra-service time of 120 minutes, total time of 210 minutes) and noted that both services involve the same amount of intra-service time and the same overall amount of physician work. **The RUC recommends a work RVU of 17.97 for CPT code 33895.**

33897 ***Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta***
The RUC reviewed the survey results from 41 interventional and pediatric interventional cardiologists and recommends 50 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time and 60 minutes of immediate post-service time. The specialties noted that, relative to adult patients with normal cardiac anatomy, the pre-service evaluation time for pediatric patients with congenital defects includes additional time to discuss a patient's procedure with the parent. Similarly, the post-procedure work includes additional time to explain the pathology of the child to the parent. Furthermore, as a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as Improving Pediatric and Adult Congenital Treatments (IMPACT), which can also add significant post procedure work time. In addition, the post-service period time typically includes time to diagram the congenital heart defect in the EHR and complete data submission to the registry.

The RUC reviewed both the survey 25th percentile work RVU of 12.00 and survey median work value of 17.00 and agreed that the appropriate value for this service should be between the 25th percentile and the median value. The RUC agreed that a direct work value crosswalk to CPT code 33340 *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation* (work RVU= 14.00, intra-service time of 90 minutes, total time of 183 minutes) and noted that both services involve an identical amount of intra-service time and overall amount of physician work. The RUC also compared the survey code to CPT code 33988 *Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS* (work RVU= 15.00, intra-service time of 90 minutes, total time of

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

250 minutes) and noted that although both services involve an identical amount of intra-service time, the reference code involves 10 more minutes of total time. **The RUC recommends a work RVU of 14.00 for CPT code 33897.**

Practice Expense
No direct practice expense inputs are recommended for CPT codes 33894, 33895 and 33897 as they are facility-only services.

Tracking CPT Code Changes that Will Impact 33894
The RUC noted that its recommendation for CPT code 33894 includes pre-service evaluation work for evaluation using a 3D-printed model of the heart which requires additional pre-service evaluation time. If a CPT code is created in the future which would enable this service to be separately reported, then 33894 should be re-reviewed.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Cardiovascular System** **Heart and Pericardium** **Endovascular Repair of Descending Thoracic Aorta** *Codes 33880-33891 represent a family of procedures to report placement of an endovascular graft for repair of the descending thoracic aorta. These codes include all device introduction, manipulation, positioning, and deployment. All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment, are not separately reportable.* *Open arterial exposure and associated closure of the arteriotomy sites (eg, 34714, 34715, 34716, 34812, 34820, 34833, 34834), introduction of guidewires and catheters (eg, 36140, 36200-36218), and extensive repair or replacement of an artery (eg, 35226, 35286) may be additionally reported. Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (eg, 33889, 33891) may be separately reported. The primary codes, 33880 and 33881, include placement of all distal extensions, if required, in the distal thoracic aorta, while proximal extensions, if needed, may be reported separately.* *For fluoroscopic guidance in conjunction with endovascular repair of the thoracic aorta, see codes 75956-75959 as appropriate. Codes 75956 and 75957 include all angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the primary endovascular devices (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff). Code 75958 includes the analogous services for placement of each proximal thoracic endovascular extension. Code 75959 includes the analogous services for placement of a distal thoracic endovascular extension(s) placed during a procedure after the primary repair.*			

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Other interventional procedures performed at the time of endovascular repair of the descending thoracic aorta should be additionally reported (eg, innominate, carotid, subclavian, visceral, or iliac artery transluminal angioplasty or stenting, arterial embolization, intravascular ultrasound) when performed before or after deployment of the aortic prostheses.

For endovascular stenting or balloon angioplasty of congenital coarctation or postsurgical recoarctation of the ascending, transverse, or descending thoracic or abdominal aorta, see 33894, 33895, 33897.

33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption);involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin*

(For radiological supervision and interpretation, use 75956 in conjunction with 33880)

Endovascular Repair of Congenital Heart and Vascular Defects

Codes 33894, 33895, 33897 describe transcatheter interventions for revascularization or repair for coarctation of the aorta. Code 33897 describes dilation of the coarctation using balloon angioplasty without stent placement. Codes 33894, 33895 describe stent placement to treat the coarctation. The procedure described in 33894 involves stent placement across one or more major side branches of the aorta. For reporting purposes, the major side branches of the thoracic aorta are the brachiocephalic, carotid, and subclavian arteries, and the major side branches of the abdominal aorta are the celiac, superior mesenteric, inferior mesenteric, and renal arteries.

Codes 33894, 33895, 33897 include all fluoroscopic guidance of the intervention, diagnostic congenital left heart catheterization, all catheter and wire introductions and manipulation, and angiography of the target lesion.

Codes 33894, 33895 include stent introduction, manipulation, positioning, and deployment, temporary pacemaker insertion for rapid pacing (33210) to facilitate stent positioning when performed, as well as any additional stent delivery in tandem with the initial stent for extension purposes. Balloon angioplasty within the target treatment zone, either before or after stent deployment, is not separately reportable. For balloon angioplasty of an additional coarctation of the aorta in a segment separate from the treatment zone for the coarctation stent, use 33897.

For balloon angioplasty of the aorta for lesions other than coarctation (eg, atherosclerosis) of the aorta in a segment separate from the coarctation treatment zone, use 37246.

For additional diagnostic right heart catheterization in the same setting as 33894, 33895, see *93X1X, 93X2X.*

Other interventional procedures performed at the time of endovascular repair of coarctation of the aorta (33894, 33895) may be separately reported (eg, innominate, carotid, subclavian, visceral, iliac, or pulmonary artery balloon angioplasty or stenting, arterial or venous embolization), when performed before or after coarctation stent deployment.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

●33894	L1	Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches	000	21.70
●33895	L2	not crossing major side branches (Do not report 33894, 33895 in conjunction with 33210, 34701, 34702, 34703, 34704, 34705, 34706, 36200, 75600, 75605, 75625, 93567, 93595, 93596, 93597) (Do not report 33894, 33895 in conjunction with 37246, 37236, 33897 for balloon angioplasty of the aorta within the coarctation stent treatment zone) (For additional atrial, ventricular, pulmonary, coronary or bypass graft angiography in the same setting, see 93563, 93564, 93565, 93566, 93568) (For angiography of other vascular structures, use the appropriate code from the Radiology/Diagnostic Radiology section) (For additional congenital right heart catheterization at same setting as 33894, 33895, see 93593, 93594)	000	17.97
●33897	L3	Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta (Do not report 33897 in conjunction with 33210, 34701, 34702, 34703, 34704, 34705, 34706, 36200, 37236, 37246, 75600, 75605, 75625, 93567, 93595, 93596, 93597) (Do not report 33897 in conjunction with 33894, 33895 for balloon angioplasty of the aorta within the coarctation stent treatment zone) (For additional congenital right heart diagnostic catheterization performed in same setting as 33897, see 93593, 93594) (For angioplasty and other transcatheter revascularization interventions of additional upper or lower extremity vessels in same setting, use the appropriate code from the Surgery/Cardiovascular System section)	000	14.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33894 Tracking Number L1 Original Specialty Recommended RVU: **23.30**
Presented Recommended RVU: **23.30**
Global Period: 000 Current Work RVU: **N/A** RUC Recommended RVU: **21.70**

CPT Descriptor: Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year-old male with hypoplastic left heart syndrome and prior history of Norwood arch reconstruction is suspected of having complex transverse arch coarctation of the surgical site. He is brought to the cardiac catheterization lab for further diagnostic evaluation and to identify if it meets criteria for intervention, and possible treatment with percutaneous stent placement.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT, or cardiac MRI. Use of 3D printed model obtained from prior cardiac MRI to simulate and plan for stent positioning and plan for appropriate equipment (catheters and wires) which will be needed. Evaluate the 3-D volume set to determine optimal projection angles to be used on biplane catheterization lab for stent implant, with particular attention to the position of the subclavian and carotid artery origins. Based on available information, determine all potential components required for the procedure plus contingencies and backups such as available stent sizes and alternatives. Perform and document a complete and/or interval history and physical exam. Provide a description of the procedure and expected results to the parents of the patient, a description of potential hazards and signature of informed consent for the procedure. Acquaint the patient or parents with the catheterization laboratory (this is standard for pediatric population to help parents with the anxiety of the procedure). Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Don surgical scrubs & lead. Position patient and prep, scrub, drape and wait.

Description of Intra-Service Work: Conduct under general anesthesia and under fluoroscopic guidance. Lidocaine is applied for local analgesia. Access is obtained percutaneously, typically into the femoral vein and artery. Additional arterial access is often also obtained in the radial, brachial, or axillary artery for simultaneous pre and post coarctation pressure evaluation during the procedure. A sheath is initially placed in the femoral vein and artery to establish secure access. Intravenous heparin is administered to achieve therapeutic anticoagulation. The activated clotting time is monitored thereafter and additional Heparin administered, as needed. A pacing catheter is passed through the venous sheath and positioned in the right ventricle for purpose of trans-venous pacing during stent delivery. Typically, a Pigtail catheter is introduced through the arterial sheath and manipulated into the descending aorta, ascending aorta, and across the aortic valve into the left ventricle. Baseline pressures may be recorded and blood sampling may be conducted in each of these locations to be used for hemodynamic calculations. Often, the coarctation is so severe; the Pigtail catheter must be exchanged for another end-hole catheter and specialty wire to cross the severe stenosis. Once the wire is across the stenosis, multiple catheter and wire exchanges are required between the end-hole catheter and angiographic catheter to obtain hemodynamic data and perform all necessary angiograms. Multiple angiograms must often be performed to clearly

delineate the lesion, with particular attention paid to the origins of the subclavian and carotid arteries. The procedure may involve stenting across either only select head and neck vessels, or the entire transverse aorta, and careful evaluation of all branches is crucial. Measurements of the lesion as well as healthy vessel are made from the angiograms, which are used for appropriate stent selection. The diagnostic catheter is used to secure wire position with a more rigid interventional guide wire needed to support balloons and stent delivery. Preparation and de-airing of the appropriately sized balloon is performed. The stent is prepared and mounted on the balloon catheter. The short access sheath in the artery is replaced over the wire for a larger and longer sheath, which is advanced across the lesion. The dilator is removed and the sheath allowed to bleed back, and flushed. The balloon with mounted stent is advanced over the wire into position across the coarctation. Repeated angiograms are periodically performed through the side port to evaluate proper positioning and make adjustments. Once in the appropriate position, the sheath is pulled back, fully exposing the stent and balloon. Trans-venous cardiac pacing is initiated to decrease the cardiac output and pulsatility in the aorta. The anesthesiologist is instructed to hold mechanical ventilation temporarily to minimize respiratory variation in the position of the stent on fluoroscopy. The stent is deployed by inflation of the delivery balloon(s). Mechanical ventilation is resumed and cardiac pacing is discontinued. The delivery balloon is removed and another appropriately sized balloon is inserted to fully expand and seat the stent (not additionally reportable). Post procedure angiography is performed to assess post procedural success. Deployment of a second stent to extend the initial stent length may be necessary, requires repeating all the above steps, and is not additionally reportable. All catheters and sheaths are removed and either manual compression or closure device is used to achieve hemostasis prior to transfer to recovery. Adequate circulation distal to the arterial access site is ensured prior to transfer to recovery area.

Description of Post-Service Work: Following catheterization, a brief procedure note is documented in the medical record. Once hemostasis of the catheterization sites has been ensured, the patient is transported to the appropriate recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed report is documented which includes an anatomically correct diagram of the congenital heart defects, detailed description of the procedure performed, calculations and interpretation of all the hemodynamic data obtained, review and radiologic interpretation of the angiograms, and complete listing and discussion of the findings, and recommendations of each. All necessary data is then also entered into the appropriate national registry, as available/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and go over discharge and follow up instructions prior to discharge, or to communicate any other instructions with the intensive care team, as may be appropriate

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Edward Toggart, MD; Lloyd Klein, MD; Sergio Bartakian, MD					
Specialty Society(ies):	American College of Cardiology, The Society for Cardiovascular Angiography and Interventions					
CPT Code:	33894					
Sample Size:	301	**Resp N:**	41			
Description of Sample:	ACC: 162 survey recipients from cross-reference of member specialty designations as pediatric cardiologists and interventional cardiologists SCAI: 139 pediatric interventional cardiologists from crossreferenceing member interests					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	4.00	25.00
Survey RVW:	10.00	18.27	**23.30**	25.00	30.00
Pre-Service Evaluation Time:			**70.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	4.00	120.00	**134.00**	180.00	200.00

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33894	**Recommended Physician Work RVU: 21.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**60.00**	**40.00**	**20.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**134.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**60.00**	**33.00**	**27.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93581	000	24.39	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33477	000	25.00	**RUC Time**

CPT Descriptor Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 29.2 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 52.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 33894	Top Key Reference CPT Code: 93581	2nd Key Reference CPT Code: 33477
Median Pre-Service Time	90.00	30.00	40.00
Median Intra-Service Time	134.00	180.00	180.00
Median Immediate Post-service Time	60.00	60.00	33.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**284.00**	**270.00**	**253.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	17%	58%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	33%	59%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	16%	42%	42%
Physical effort required	8%	67%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	17%	83%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	56%	22%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	22%	34%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	44%	34%	22%
Physical effort required	56%	22%	22%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	11%	78%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

Coarctation of the aorta occurs in 6% to 8% of patients with congenital heart disease and is commonly associated with other intracardiac pathology. When uncorrected, coarctation of the aorta is associated with reduced life expectancy secondary to heart failure, rupture of associated aortic aneurysm or cerebral aneurysm, and infective endocarditis. Coarctation in infancy is usually a catastrophic illness and is associated with congestive heart failure, demanding

immediate and aggressive treatment. there is currently no way in CPT to track patients undergoing endovascular repair of coarctation of the aorta due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work. In October 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel: Codes **33894**, 33895 33897. These new codes describe transcatheter interventions for revascularization or repair for coarctation of the aorta. Code 33897 describes dilation of the coarctation using balloon angioplasty without stent placement. Codes 33894, 33895 describe stent placement to treat the coarctation. **The procedure described in 33894 involves stent placement across one or more major side branches of the aorta. For reporting purposes, the major side branches of the thoracic aorta are the brachiocephalic, carotid, and subclavian arteries, and the major side branches of the abdominal aorta are the celiac, superior mesenteric, inferior mesenteric, and renal arteries.**

The ACC and SCAI randomly surveyed interventional pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service. This is the first of three new codes to report endovascular repair of aortic coarctation.

The key reference code is 93581 for percutaneous transcatheter closure of a congenital ventricular septal defect with implant. It was selected by 29% of respondents. Three quarters of the respondents indicated that 33894 was more complex. The second reference code was 33477 for transcatheter pulmonary valve implantation. It was selected by approximately 22% of respondents. About 30% of the respondents indicated that 33894 was more intense/complex overall.

Preservice and Postservice Time

The societies recommend the complete preservice time from the survey, adding 30 minutes to evaluation, 12 minutes for positioning, and reducing the SDW time by 5 minutes comporting with the survey. As explained with other pediatric/congenital percutaneous transcatheter services in recent meetings, additional time beyond the normal adult package is spent reviewing imaging and preparing products/devices for the procedure. With 33894, this includes evaluation using a 3D-printed model of the heart. Time to discuss a patient's procedure with the parent also takes considerably more time as compared to discussing with an adult patient consenting for themselves. This same problem is further involved in the post procedure segment of work in having to explain the pathology of the child to the parent. As a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. Longer positioning time is necessary for pediatric patients.

The societies also recommend the complete post-service time from the survey as we believe it correctly captures additional time that is typically spent to monitor patient recovery/stabilization, speak with the family who are typically parents concerned about their young child, and complete post-operative note. Package 9B with the placement of these additional minutes is presented below.

	9B General Anesthesia or Complex Regional Block/Complex Procedure	
Total Post-Service Time	**60**	
Details:		
Application of Dressing[1]	2	
Transfer of supine patient off table	1	+2
Operative Note	5	
Monitor patient recovery/stabilization	10	
Communication with patient and/or family	5	+10
Written post-operative note	5	+15
Post-Operative Orders and Order Entry	5	

Recommendation

Therefore, for code 338X the **societies recommend an RVW of 23.30 with 100 minutes preservice time, 134 minutes intraservice time from the survey median, and 60 minutes postservice time**. This aligns with the KRS, which survey

respondents felt was less intense than 33894; 93581 has a longer intraservice time, shorter total time than our recommended times for 33894, and lower IWPUT. Finally, this service compares to 93590 for repair of a paravalvular leak, as shown in the summary spreadsheet, which has a nearly identical intraservice time, shorter total time, and lower work RVU.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 or 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty pediatric interventional cardiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 320
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Coarctation of the aorta comprises 5% to 8% of all congenital heart defects. With an estimated annual birth rate of between 3.8 to 4 million per year, and a rate of congenital heart disease at a fixed 1% of total births, the prevalence of disease can be estimated at between 1900 to 3200 cases per year. Stents with side branches are roughly 10% of these procedures.

Specialty pediatric interventional cardiology Frequency 320 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. should only be pediatric procedures

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33895 Tracking Number L2 Original Specialty Recommended RVU: **20.00**
Presented Recommended RVU: **20.00**
Global Period: 000 Current Work RVU: **N/A** RUC Recommended RVU: **17.97**

CPT Descriptor: Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; not crossing major side branches

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old male with hypertension is found to have severe native coarctation of the aorta by echocardiography and/or CT angiogram. He is brought to the cardiac catheterization lab for further diagnostic evaluation to identify if it meets criteria for intervention, and possible repair with percutaneous stent placement.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT or MRI, or any other pertinent studies. Based on available information, determine all potential components required for the procedure plus contingencies and backups. Perform and document a complete and/or interval history and physical exam. Provide a description of the procedure and expected results to the parents of the patient, a description of potential hazards and signature of informed consent for the procedure. Acquaint the patient or parents with the catheterization laboratory. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Don surgical scrubs & lead. Position patient. Prep, scrub, drape and wait.

Description of Intra-Service Work: Procedure is conducted under general anesthesia. All steps are performed under fluoroscopic guidance. Lidocaine is administered for local analgesia. Access is obtained percutaneously, typically into the femoral vein and artery. Additional arterial access is often also obtained in the radial, brachial, or axillary artery for simultaneous pre and post coarctation pressure evaluation during the procedure. A sheath is initially placed in the femoral vein and artery to establish secure access. Intravenous heparin is administered to achieve therapeutic anticoagulation. The activated clotting time is monitored thereafter and additional Heparin administered, as needed. A pacing catheter is passed through the venous sheath and positioned in the right ventricle for purpose of temporary trans-venous pacing during stent delivery. Typically a Pigtail catheter is introduced through the arterial sheath and manipulated into the descending aorta, ascending aorta, and across the aortic valve into the left ventricle. Baseline pressures may be recorded and blood sampling may be conducted in each of these locations to be used for hemodynamic calculations. Often, the coarctation is so severe; the Pigtail catheter must be exchanged for another end-hole catheter and specialty wire to cross the severe stenosis. Once the wire is across the stenosis, multiple catheter and wire exchanges are required between the end-hole catheter and angiographic catheter to obtain hemodynamic data and perform all necessary angiograms. Multiple angiograms must often be performed above and below the lesion to identify the complete anatomy. Measurements of the lesion as well as healthy vessel are made from the angiograms, which are used for appropriate stent selection. A diagnostic guide catheter is used to secure wire position with a more rigid interventional guide wire needed to support balloons and stent delivery. Preparation and de-airing of the appropriately sized balloon is performed. The stent is prepared and mounted on the balloon catheter. The short access sheath in the artery is replaced over the wire for a larger and longer sheath, which is advanced across the lesion. The dilator is removed and the sheath allowed to bleed back, and flushed. The balloon with mounted stent is

advanced over the wire into position across the coarctation. Repeated angiograms are performed through the long sheath side port or from an additional arterial access site to evaluate proper positioning and make adjustments, and ensure the stent will not encroach on the origins of any vital side branches. Once in the appropriate position, the sheath is pulled back, fully exposing the stent and balloon. The anesthesiologist is instructed to hold mechanical ventilation to minimize stent position movement on fluoroscopy. Rapid trans-venous cardiac pacing is initiated to reduce aortic pulsatility and cardiac output. The stent is deployed by inflation of the delivery balloon(s). Mechanical ventilation is resumed and cardiac pacing is discontinued. The balloon is deflated and repositioned slightly and a second inflation typically performed. The delivery balloon is removed and another appropriately sized balloon is inserted to fully expand and seat the stent (not additionally reportable). Post procedure angiography is performed to assess post procedural success. Deployment of a second stent to extend the initial stent length may be necessary, requires repeating all the above steps, and is not additionally reportable. All catheters and sheaths are removed and either manual compression or closure device is used to achieve hemostasis prior to transfer to recovery. Adequate circulation distal to the arterial access site is ensured prior to transfer to recovery area.

Description of Post-Service Work: Following catheterization, a brief procedure note is documented in the medical record. Once hemostasis of the catheterization sites has been ensured, the patient is transported to the appropriate recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed report is documented which includes an anatomically correct diagram of the congenital heart defects, detailed description of the procedure performed, calculations and interpretation of all the hemodynamic data obtained, review and radiologic interpretation of the angiograms, and complete listing and discussion of the findings, and recommendations of each. All necessary data is then also entered into the appropriate national registry, as available/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and go over discharge and follow up instructions prior to discharge, or to communicate any other instructions with the intensive care team, as may be appropriate

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Edward Toggart, MD; Lloyd Klein, MD; Sergio Bartakian, MD					
Specialty Society(ies):	American College of Cardiology, The Society for Cardiovascular Angiography and Interventions					
CPT Code:	33895					
Sample Size:	301	**Resp N:**	41			
Description of Sample:	ACC: 162 survey recipients from cross-reference of member specialty designations as pediatric cardiologists and interventional cardiologists SCAI: 139 pediatric interventional cardiologists from crossreferenceing member interests					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**5.00**	6.00	20.00
Survey RVW:	9.50	15.00	**20.00**	22.00	24.00
Pre-Service Evaluation Time:			**70.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	4.00	90.00	**120.00**	150.00	180.00

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33895	**Recommended Physician Work RVU: 17.97**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**60.00**	**33.00**	**27.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93590	000	21.70	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 100.0 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 70.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 33895	Top Key Reference CPT Code: 93590	2nd Key Reference CPT Code: **93580**
Median Pre-Service Time	80.00	40.00	30.00
Median Intra-Service Time	120.00	135.00	120.00
Median Immediate Post-service Time	60.00	30.00	60.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**260.00**	**205.00**	**210.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	30%	30%	30%	10%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	40%	30%	30%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	50%	20%	30%
Physical effort required	50%	20%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	20%	60%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	14%	86%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	14%	86%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	29%	71%
Physical effort required	0%	29%	71%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	14%	86%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

Coarctation of the aorta occurs in 6% to 8% of patients with congenital heart disease and is commonly associated with other intracardiac pathology. When uncorrected, coarctation of the aorta is associated with reduced life expectancy secondary to heart failure, rupture of associated aortic aneurysm or cerebral aneurysm, and infective endocarditis. Coarctation in infancy is usually a catastrophic illness and is associated with congestive heart failure, demanding

immediate and aggressive treatment. there is currently no way in CPT to track patients undergoing endovascular repair of coarctation of the aorta due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work. In October 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel: Codes 33894, **33895**, 33897. These new codes describe transcatheter interventions for revascularization or repair for coarctation of the aorta. Codes 33894, **33895** include stent introduction, manipulation, positioning, and deployment, temporary pacemaker insertion for rapid pacing (33210) to facilitate stent positioning when performed, as well as any additional stent delivery in tandem with the initial stent for extension purposes. Balloon angioplasty within the target treatment zone, either before or after stent deployment, is not separately reportable.

Other interventional procedures performed at the time of endovascular repair of coarctation of the aorta (33894, **33895**) may be separately reported (eg, innominate, carotid, subclavian, visceral, iliac, or pulmonary artery balloon angioplasty or stenting, arterial or venous embolization), when performed before or after coarctation stent deployment.

The ACC and SCAI randomly surveyed pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service. This is the second of three new codes to report endovascular repair of aortic coarctation.

The key reference code is 93590 for percutaneous transcatheter closure of paravalvular leak. It was selected by 24% of respondents. 40% respondents indicated that 33895 was more complex. The second reference code was 93580 for Percutaneous transcatheter closure of congenital interatrial communication. It was selected by approximately 17% of respondents. About 86% of the respondents indicated that 33895 was more intense/complex overall.

Preservice and Postservice Time

The societies recommend additional preservice time from the survey, adding 10 minutes to evaluation, 12 minutes for positioning, and reducing the SDW time by 5 minutes comporting with the survey. As explained with other pediatric/congenital percutaneous transcatheter services in recent meetings, additional time beyond the normal adult package is spent reviewing imaging and preparing products/devices for the procedure. Time to discuss a patient's procedure with the parent also takes considerably more time as compared to discussing with an adult patient consenting for themselves. This same problem is further involved in the post procedure segment of work in having to explain the pathology of the child to the parent. As a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. Longer positioning time is necessary for pediatric patients.

The societies recommending the complete post-service time from the survey as we believe it correctly captures additional time that is typically spent to monitor patient recovery/stabilization, speak with the family who are typically parents concerned about their teenager, and complete post-operative note. Package 9B with the placement of these additional minutes is presented below.

	9B General Anesthesia or Complex Regional Block/Complex Procedure	
Total Post-Service Time	**60**	
Details:		
Application of Dressing[1]	2	
Transfer of supine patient off table	1	+2
Operative Note	5	
Monitor patient recovery/stabilization	10	
Communication with patient and/or family	5	+10
Written post-operative note	5	+15
Post-Operative Orders and Order Entry	5	

Recommendation

Therefore, for code 338X the **societies recommend an RVW of 20.00 with 80 minutes preservice time, 120 minutes intraservice time from the survey median, and 60 minutes postservice time**. This aligns with the KRS, which survey respondents felt was close in intensity to 33895; 93590 has a longer intraservice time, shorter total time than our recommended times for 33895, and barely higher IWPUT.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 or 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty pediatric interventional cardiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1920
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Coarctation of the aorta comprises 5% to 8% of all congenital heart defects. With an estimated annual birth rate of between 3.8 to 4 million per year, and a rate of congenital heart disease at a fixed 1% of total births, the prevalence of disease can be estimated at between 1900 to 3200 cases per year. Stents without side branches are roughly 60% of these procedures.

Specialty pediatric interventional cardiologists Frequency 1920 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. should be only pediatric procedures

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33897 Tracking Number L3 Original Specialty Recommended RVU: **17.00**
Presented Recommended RVU: **17.00**
Global Period: 000 Current Work RVU: **N/A** RUC Recommended RVU: **14.00**

CPT Descriptor: Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-year-old female with prior surgical repair of coarctation of the aorta in infancy is suspected to have recurrent coarctation of the aorta by echocardiography and physical exam. She is brought to the cardiac catheterization lab for further diagnostic evaluation to identify if she meets criteria for intervention, and possible percutaneous angioplasty of the aorta.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT or MRI, or any other pertinent studies. Based on available information, determine all potential components required for the procedure plus contingencies and backups. Perform and document a complete and/or interval history and physical exam. Provide a description of the procedure and expected results to the parents of the patient, a description of potential hazards and signature of informed consent for the procedure. Acquaint the patient or parents with the catheterization laboratory. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Don surgical scrubs & lead. Position patient. Prep, scrub, drape and wait.

Description of Intra-Service Work: Procedure is conducted under general anesthesia. All steps are performed under fluoroscopic guidance. Local anesthetic is applied to the access site. Access is obtained percutaneously, typically into the femoral artery and vein. Additional arterial monitoring may also be performed from the radial artery for simultaneous pre and post coarctation pressure evaluation. For neonates, this additional access is typically obtained in the common carotid artery. A sheath is initially placed in the vein and artery to establish secure access. Intravenous heparin is administered to achieve therapeutic anticoagulation. The activated clotting time is monitored thereafter and additional Heparin administered, as needed. Venous access is typically obtained for either resuscitation purposes for emergent situations, or for trans-venous ventricular pacing, when performed. Typically a Pigtail catheter is introduced through the arterial sheath and manipulated into the descending aorta, ascending aorta, and across the aortic valve into the left ventricle. Baseline pressures may be recorded and blood sampling may be conducted in each of these locations to be used for hemodynamic calculations. Often, the coarctation is so severe; the Pigtail catheter must be exchanged for another end-hole catheter and specialty wire to cross the severe stenosis. Multiple exchanges are often required between the Pigtail catheter and end-hole catheter to obtain hemodynamic data and perform all necessary angiograms. Multiple angiograms of the aorta must often be performed above and below the lesion to identify the complete anatomy. Measurements of the lesion as well as healthy vessel are made from the angiograms, which are used for appropriate balloon selection. A diagnostic guide catheter is used to secure wire position with a more rigid guide wire needed to support the balloons. Preparation and de-airing of the appropriately sized balloon is performed. The sheath in the artery is exchanged for a larger sheath to accommodate the angioplasty balloon. The balloon is advanced over the wire into position across the coarctation. Once in the appropriate position, the balloon is inflated to the appropriate pressure. The balloon catheter position is often adjusted slightly and a

repeat inflation performed. The balloon is removed and post angioplasty angiograms performed from multiple angles to closely examine for the presence of any vascular injury. Hemodynamic evaluation is repeated to assess post procedural success. It is often necessary to repeat this process with a larger balloon to achieve optimal success, and not additionally reportable. All catheters and sheaths are removed and manual compression is used to achieve hemostasis prior to transfer to recovery. Adequate circulation distal to the arterial access site is ensured prior to transfer to recovery area.

Description of Post-Service Work: Following catheterization, a brief procedure note is documented in the medical record. Once hemostasis of the catheterization sites has been ensured, the patient is transported to the appropriate recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed report is documented which includes an anatomically correct diagram of the congenital heart defects, detailed description of the procedure performed, calculations and interpretation of all the hemodynamic data obtained, review and radiologic interpretation of the angiograms, and complete listing and discussion of the findings, and recommendations of each. All necessary data is then also entered into the appropriate national registry, as available/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and go over discharge and follow up instructions prior to discharge, or to communicate any other instructions with the intensive care team, as may be appropriate

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Edward Toggart, MD; Lloyd Klein, MD; Sergio Bartakian, MD					
Specialty Society(ies):	American College of Cardiology, The Society for Cardiovascular Angiography and Interventions					
CPT Code:	33897					
Sample Size:	301	**Resp N:**	41			
Description of Sample:	ACC: 162 survey recipients from cross-reference of member specialty designations as pediatric cardiologists and interventional cardiologists SCAI: 139 pediatric interventional cardiologists from crossreferenceing member interests					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**6.00**	8.00	25.00
Survey RVW:	8.00	12.00	**17.00**	19.50	24.00
Pre-Service Evaluation Time:			**65.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	4.00	75.00	**90.00**	120.00	180.00

Immediate Post Service-Time:	**60.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33897	**Recommended Physician Work RVU: 14.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**60.00**	**33.00**	**27.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93590	000	21.70	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leakPercutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve; initial occlusion device, mitral valve

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 76.4 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 29.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 33897	Top Key Reference CPT Code: 93580	2nd Key Reference CPT Code: **93590**
Median Pre-Service Time	80.00	30.00	40.00
Median Intra-Service Time	90.00	120.00	135.00
Median Immediate Post-service Time	60.00	60.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**230.00**	**210.00**	**205.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	8%	38%	54%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	38%	54%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	23%	54%	23%
Physical effort required	23%	54%	23%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	31%	69%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	20%	40%	20%	0%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	60%	40%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	60%	20%	20%
Physical effort required	60%	20%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	60%	20%	20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History and Background

Coarctation of the aorta occurs in 6% to 8% of patients with congenital heart disease and is commonly associated with other intracardiac pathology. When uncorrected, coarctation of the aorta is associated with reduced life expectancy secondary to heart failure, rupture of associated aortic aneurysm or cerebral aneurysm, and infective endocarditis. Coarctation in infancy is usually a catastrophic illness and is associated with congestive heart failure, demanding

immediate and aggressive treatment. there is currently no way in CPT to track patients undergoing endovascular repair of coarctation of the aorta due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work. In October 2020, the ACC and SCAI presented a code change application to the CPT Editorial Panel: Codes 33894, 33895, **33897.** These new codes describe transcatheter interventions for revascularization or repair for coarctation of the aorta. Code 33897 describes dilation of the coarctation using balloon angioplasty without stent placement. Codes 33894, 33895 describe stent placement to treat the coarctation. **For balloon angioplasty of an additional coarctation of the aorta in a segment separate from the treatment zone for the coarctation stent, use 33897.**

The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service. This is the last of three new codes to report endovascular repair of aortic coarctation.

The key reference code is 93580 for percutaneous transcatheter closure of a congenital interatrial communication. It was selected by approximately 32% of respondents. 54% of the respondents indicated that 33897 was more complex. The second reference code was 93590 for percutaneous transcatheter closure of paravalvular leak. It was selected by approximately 12% of respondents. About 20% of the respondents indicated that 33894 was more intense/complex overall.

Preservice and Postservice Time

The societies recommend additional preservice time from the survey, adding 10 minutes to evaluation, 12 minutes for positioning, and reducing the SDW time by 5 minutes comporting with the survey. As explained with other pediatric/congenital percutaneous transcatheter services in recent meetings, additional time beyond the normal adult package is spent reviewing imaging and preparing products/devices for the procedure. Time to discuss a patient's procedure with the parent also takes considerably more time as compared to discussing with an adult patient consenting for themselves. This same problem is further involved in the post procedure segment of work in having to explain the pathology of the child to the parent. As a national standard, congenital heart programs are now also required to enter hemodynamic data and other procedural details into national registries such as IMPACT, which can also add significant post procedure work time. Longer positioning time is necessary for pediatric patients.

The societies recommending the complete post-service time from the survey as we believe it correctly captures additional time that is typically spent to monitor patient recovery/stabilization, speak with the family who are typically parents concerned about their young child, and complete post-operative note. Package 9B with the placement of these additional minutes is presented below.

	9B General Anesthesia or Complex Regional Block/Complex Procedure	
Total Post-Service Time	**60**	
Details:		
Application of Dressing[1]	2	
Transfer of supine patient off table	1	+2
Operative Note	5	
Monitor patient recovery/stabilization	10	
Communication with patient and/or family	5	+10
Written post-operative note	5	+15
Post-Operative Orders and Order Entry	5	

Recommendation

Therefore, for code 33897 the **societies recommend the survey median RVW of 17.00 with 80 minutes preservice time, 90 minutes intraservice time from the survey median, and 60 minutes postservice time**. This aligns with the KRS,

which survey respondents felt was less intense than 33897; 93580 has a longer intraservice time, shorter total time than our recommended times for 33897, and lower IWPUT.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37799 or 93799

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty peditric interventional cardiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 960
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Coarctation of the aorta comprises 5% to 8% of all congenital heart defects. With an estimated annual birth rate of between 3.8 to 4 million per year, and a rate of congenital heart disease at a fixed 1% of total births, the prevalence of disease can be estimated at between 1900 to 3200 cases per year. Balloon-only cases are roughly 30% of these procedures.

Specialty pediatric interventional cardiology Frequency 960 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. should only be pediatric procedures

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

SS Rec Summary

ISSUE: Endovascular Repair of Aortic Coarctation (33894, 33895, 33897)

TAB: 8

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93581	000	Percutaneous transcatheter closure of a congenital	12	0.1243	0.090			24.39			270	30					180			60					
2nd REF	33477	000	Transcatheter pulmonary valve implantation, percutaneous	9	0.1285	0.091			25.00			276	40	3	20			180			33					
CURRENT	93799	000	Unlisted cardiovascular service or procedure		#DIV/0!	#DIV/0!						0														
SVY	33894	000	Endovascular stent repair of coarctation of the ascending,	41	0.147	0.077	10.00	18.27	23.30	25.00	30.00	304	70	25	15	4	120	134	180	200	60	0	1	2	4	25
REC	33894	000	Endovascular stent repair of coarctation of the ascending,		0.138	0.076			21.70			284	60	15	15			134			60					
XWLK	93590	000	Percutaneous transcatheter closure of paravalvular leak;		0.148	0.097			21.70			223	40	3	15			135			30					
COMP	33745	000	Transcatheter intracardiac shunt (TIS) creation by stent		0.192	0.097			20.00			207	25	15	15			92			60					

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93590	000	Percutaneous transcatheter closure of paravalvular leak;	10	0.1477	0.097			21.70			223	40	3	15			135			30					
2nd REF	93580	000	Percutaneous transcatheter closure of congenital interatrial	7	0.133	0.086			17.97			210	30					120			60					
CURRENT	93799		Unlisted cardiovascular service or procedure		#DIV/0!	#DIV/0!						0														
SVY	33895	000	Endovascular stent repair of coarctation of the ascending,	41	0.139	0.071	9.50	15.00	20.00	22.00	24.00	280	70	15	15	4	90	120	150	180	60	1	4	5	6	20
REC	33895	000	Endovascular stent repair of coarctation of the ascending,		0.125	0.069			17.97			260	50	15	15			120			60					
XWALK	93591	000	Percutaneous transcatheter closure of paravalvular leak;		0.135	0.086			17.97			208	40	3	15			120			30					
COMP	93580	000	Endovascular stent repair of coarctation of the ascending,		0.133	0.086			17.97			210	30					120			60					
COMP	93590	000	Percutaneous transcatheter closure of paravalvular leak;		0.148	0.097			21.70			223	40	3	15			135			30					
COMP	33745	000	Transcatheter intracardiac shunt (TIS) creation by stent		0.192	0.097			20.00			207	25	15	15			92			60					

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93580	000	Percutaneous transcatheter closure of congenital interatrial	13	0.133	0.086			17.97			210	30					120			60					
2nd REF	93590	000	Percutaneous transcatheter closure of paravalvular leak;	5	0.148	0.097			21.70			223	40	3	15			135			30					
CURRENT	93799		Unlisted cardiovascular service or procedure		#DIV/0!	#DIV/0!						0														
SVY	33897	000	Percutaneous transluminal angioplasty of native or	41	0.153	0.069	8.00	12.00	17.00	19.50	24.00	245	65	15	15	4	75	90	120	180	60	1	3	6	8	25
REC	33897	000	Percutaneous transluminal angioplasty of native or		0.123	0.061			14.00			230	50	15	15			90			60					
XWLK	33340	000	Percutaneous transcatheter closure of the left atrial		0.136	0.077			14.00			183	40	3	20			90			30					
COMP	33745	000	Transcatheter intracardiac shunt (TIS) creation by stent		0.192	0.097			20.00			207	25	15	15			92			60					

December 14, 2020

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Tab 8 Endovascular Repair of Aortic Coarctation Practice Expense

Dear Dr. Manaker:

Tab 8 on the January 2021 RUC agenda addresses three new codes, which describe transcatheter interventions for revascularization or repair for coarctation of the aorta. These services are provided exclusively in the facility setting. As such, we recommend no direct practice expense inputs for Tab 8.

Thank you for your consideration of this information as you prepare for the meeting. Please contact Claudia Vasquez at cvasquez@acc.org if you have any questions.

Sincerely,

Richard Wright, MD
ACC RUC Advisor

Edward Toggart, MD
SCAI RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Harvest of Upper Extremity Artery, Endoscopic and Open – Tab 9

In May 2020, the CPT Editorial Panel created CPT code 33509 harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic to describe endoscopic radial artery harvest via an endoscopic approach and CPT code 35600 *Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open* was modified to only include an open approach for the upper extremity harvesting procedure.

At the October 2020 RUC meeting, the specialty societies explained that the rationale for assigning these services an XXX global period instead of a ZZZ, even though the service is almost exclusively performed in conjunction with an arterial coronary artery bypass grafting (CABG) procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their National Provider Identifier (NPI) number. It was noted that it is often a Nurse Practitioner (NP) or Physician's Assistant (PA) who performs the harvest procedure. The RUC agreed that since NPs and PAs were not included in the survey sample for the October 2020 meeting survey process, it would be appropriate to assign 33509 and 35600 interim values and to request for them to be resurveyed for the January 2021 RUC meeting to include these providers who are potentially the dominant providers.

During their January 2021 presentation, the specialty societies noted that the radial artery is typically used in situations where a patient is undergoing a re-operative CABG procedure where the intrathoracic arteries have already been used and/or in patients with limited saphenous vein conduit available due to prior use in peripheral vascular disease operations or use in a previous CABG procedure. Recent studies appear to indicate that use of radial-artery grafts for CABG may result in better postoperative outcomes than the use of saphenous-vein grafts. As a result of these circumstances, use of the radial artery in CABG has been increasing. Originally the radial artery was harvested using an open technique, but with technological advances, it is now possible to harvest the radial artery using an endoscopic technique and this method of harvest, where available, is now the preferred method for harvesting the radial artery.

33509 ***Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic***
The RUC reviewed the specialty societies' recommended work RVU at the survey 25th percentile of 3.75 from 84 cardiothoracic surgeons, cardiothoracic and cardiovascular surgical physician assistants and nurse practitioners, and concurred that the survey respondents appropriately valued the work involved in performing this service. The RUC recommends an intra-service time of 35 minutes for CPT code 33509.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The specialty societies explained the rationale for assigning this service an XXX global period instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their NPI number.

To justify a value of 3.75, the RUC compared the survey code to CPT code 36228 *Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)* (work RVU= 4.25 and intra-service time of 30 minutes) and noted that although the reference code includes less physician time, it is a relatively more intense service to perform, supporting a somewhat lower value for the survey code. The RUC also compared the survey code to CPT code 22512 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)* (work RVU= 4.00, intra-service time of 30 minutes, total time of 32 minutes) and noted that the survey code involves somewhat more intra-service and total time but is slightly less intense to perform, supporting a work value of 3.75 for the survey code. **The RUC recommends a work RVU of 3.75 for CPT code 33509.**

35600 ***Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open***
The RUC reviewed the specialty societies' recommended work RVU at the survey 25th percentile of 4.00 from 72 cardiothoracic surgeons, cardiothoracic and cardiovascular surgical physician assistants and nurse practitioners, and concurred that the survey respondents appropriately valued the work involved in performing this service. The RUC recommends intra-service time of 40 minutes for CPT code 35600. The specialties explained that the open approach for harvesting an upper extremity artery involves somewhat more time relative to the endoscopic approach.

The specialty societies explained that the rationale for assigning this service an XXX global period instead of a ZZZ add-on code, even though the service is almost exclusively performed in conjunction with an arterial CABG procedure (CPT codes 33533 – 33536), is that an XXX global would allow the individual that performs the harvest of upper extremity artery procedure (often separate from the surgeon performing the base CABG procedure) to report it under their NPI number.

The RUC compared the survey code to MPC code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 4.13, intra-service and total time of 40 minutes) and noted that both services involve an identical amount of time and are both major surgical procedure add-on services for accessing an artery via an open approach. The RUC also compared the survey code to CPT code 36908 *Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)* (work RVU= 4.25, intra-service and total time of 40 minutes) and noted that both services involve identical times. **The RUC recommends a work RVU of 4.00 for CPT code 35600.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Practice Expense
No direct practice expense inputs are recommended for CPT codes 33509 and 35600 **as they are facility-only services.**

Modifier-51 Exempt Status
CPT codes 33509 and 35600 are recommended to be placed on the Modifier -51 Exempt list, as these services are performed a large majority of the time with a coronary artery bypass procedure, though typically it is a separate provider (such as an NP or PA) that is performing the harvest of upper extremity artery procedure and therefore would be reporting 33509 or 35600 as a standalone code on a separate claim.

New Technology
CPT codes 33509 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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

RUC Database Flag
CPT codes 35600 and 33509 are performed a large majority of the time with a coronary artery bypass procedure, though typically it is a separate provider (such as an NP or PA) that is performing the harvest of upper extremity artery procedure and therefore would be reporting 33509 or 35600 as a standalone code on a separate claim. Due to this, these services were valued like add-on codes, though can be separately reported and may include some physician work related to patient evaluation within the intra-service time. The RUC notes that they should be flagged as "**Do not use to validate for physician work."**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Cardiovascular System** **Heart and Pericardium** **Endoscopy**				
To report endoscopic harvesting of a vein for coronary artery bypass procedure, use 33508 in addition to the code for the associated bypass procedure. To report endoscopic harvesting of an upper extremity artery for a bypass procedure, use 33509. *Surgical vascular endoscopy always includes diagnostic endoscopy.*				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

✚*33508*	*Endoscopy, surgical, including video-assisted harvest of vein(s) for coronary artery bypass procedure (List separately in addition to code for primary procedure)* *(Use 33508 in conjunction with 33510-33523)* *(For open harvest of upper extremity vein procedure, use 35500)*			
■33509	B1	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic (For open harvest of upper extremity artery, use 35600) (For bilateral procedure, report 33509 with modifier 50)	XXX	3.75

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Heart and Pericardium
Combined Arterial-Venous Grafting for Coronary Bypass

The following codes …

To report combined arterial-venous …

Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 33509 or 35600 ~~in addition to the bypass procedure~~. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see *~~33990-33993~~33990, 33991, 33992, 33993, 33995, 33997.*

✚*33517* *Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)*

(Use 33517 in conjunction with 33533-33536)

Arterial Grafting for Coronary Artery Bypass

The following codes …

To report combined …

Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 33509 or 35600 ~~in addition to the bypass procedure~~. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see *~~33990-33993~~33990, 33991, 33992, 33993, 33995, 33997.*

33533 *Coronary artery bypass, using arterial graft(s); single arterial graft*

Arteries and Veins
Bypass Graft
Other Than Vein

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

▲35600	B2	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open ~~(List separately in addition to code for primary procedure)~~ ~~(Use 35600 in conjunction with 33533–33536)~~ (For bilateral procedure, report 35600 with modifier 50) (For endoscopic approach, see 33509, 33508, 37500)	XXX ~~ZZZ~~	4.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33509 Tracking Number B1 Original Specialty Recommended RVU: **3.75**
Presented Recommended RVU: **3.75**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **3.75**

CPT Descriptor: Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old male presents to the emergency room with unstable angina. He has history of coronary artery bypass graft (CABG). Cardiac catheterization reveals multivessel disease requiring several grafts. He is an acceptable candidate for re-operation CABG. Saphenous vein conduit is limited because of prior CABG and only a small segment available. The right internal mammary artery is available, the left radial artery in this right-handed individual is evaluated and appropriate for endoscopic harvesting and use for coronary artery bypass grafting

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The decision to utilize the radial artery as a conduit for CABG is made by the primary surgeon, typically during the initial visit with the patient. The primary surgeon performing the CABG obtains a history with attention given to conditions which may mitigate against using the radial such as renal failure requiring or likely to require dialysis, severe PVD or history of Reynaud syndrome. The arm and hand are examined and an Allen's test is performed to assess adequacy of the ulnar circulation and the palmar arch. An oxygen saturation monitor is also employed if available to assess the circulation provided by the ulnar artery.

At the time of CABG procedure (reported separately), the radial artery is checked in the operating room by the provider who will be harvesting the artery. An Allen's test utilizing the oxygen saturation monitor is performed to assess adequacy of the ulnar circulation and the palmar arch. Any abnormalities or concerns are discussed with the primary surgeon and a decision is made to proceed with harvest. The radial artery is typically harvested simultaneously while other conduits are also being harvested. The arm is positioned on a surgical arm board, a tourniquet is placed high on the upper arm in anticipation of later inflation. The appropriate endoscopic equipment is set up and tested. A continuous nitroglycerin intravenous infusion is begun to prevent spasm of the radial artery. A 3 cm longitudinal incision is made proximal to the wrist crease over the radial artery. The radial artery is identified by dissection and clamped. Pulse oximetry on the index finger is checked to assess integrity of the arterial palmar arch and the adequacy of ulnar artery flow while the radial artery is clamped. The forearm is then wrapped tightly with an Esmark bandage distal to proximal in order to evacuate the blood. The tourniquet is then inflated to 75-100 mmHg over systolic blood pressure, not exceeding 250 mmHg total, and the Esmark bandage removed. The radial artery is dissected as a pedicle with the accompanying venae comitantes and the endoscope advanced over the anterior pedicle enough to allow insertion of the port. The trocar port is inflated and CO2 is insufflated at a pressure of 10- 12 mmHg with a flow rate of 3-5 L/min creating a working tunnel. The endoscope is advanced to perform the anterior dissection along the pedicle, taking care to secure veins on each side of the radial artery. This is performed while minimizing any contact with the artery, itself. The dissection is continued to the level of the recurrent radial artery or venous plexus in the antecubital fossa being careful to avoid all nerves and larger vessels. The endoscope is withdrawn back to the port, and then advanced posteriorly to the radial artery pedicle. The posterior arterial

branches are dissected to the level of the recurrent radial or venous plexus in the antecubital fossa. The endoscope is again withdrawn to the port and then advanced laterally for similar dissection. Fasciotomy of the brachioradialis muscle is performed to enhance visualization by opening up the working tunnel using sharp dissection and applying energy from an appropriate power supply (electrocautery) to cut the tissue. Extreme caution is used to avoid untoward thermal injury to neural or vascular tissues during bracheoradialis fasciotomy. The fascia is released from the distal forearm to the mid or proximal forearm. With the fasciotomy complete, arterial branches are divided using the power source by working proximal to distal. Pulse oximetry on the thumb is rechecked. Before dividing the radial artery, a soft non-occluding clamp is placed across the dissected but still intact radial artery and palpation of the ulnar artery is performed to be certain that there is adequate blood supply to the hand. Only after adequacy of ulnar artery flow is confirmed, is the radial artery pedicle divided, ligated and then withdrawn in a retrograde fashion externally through the port. The port is withdrawn and the radial artery is divided and ligated at the wrist area using standard technique. The tourniquet is deflated and removed. The wound is carefully inspected for hemostasis. The fascia and subcutaneous tissues at the wrist incision are closed in two layers using absorbable sutures, and the skin is closed by a subcuticular method using monofilament absorbable sutures. The hand is checked for warmth and circulation is assessed with an oxygen saturation monitor. The arm is wrapped and a methylene blue marking pen is used to score the artery on its anterior surface so as maintain orientation of the radial artery conduit without inadvertent twisting. The radial artery is soaked and flushed with papaverine and heparinized patient blood. The entire length of the radial artery is checked while flushing it with the heparinized blood and branches are carefully clipped or tied per routine.

The primary surgeon uses the radial artery to bypass the designated coronary. The primary surgeon evaluates the radial artery harvest site at the end of the procedure.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	James Levett, MD (STS); Stephen Lahey, MD; (AATS); Joseph Turek, MD (STS); Jacob Schroder, MD (STS); Francis Nichols, MD (STS); Prashanath Vallabhajosyula. MD (STS); Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA (ANA); Folusho Ogunfiditimi, PA (AAPA)					
Specialty Society(ies):	AAPA; AATS; ANA; STS					
CPT Code:	33509					
Sample Size:	3991	**Resp N:**	84			
Description of Sample:	Random sample of 1441 US self-identified cardiac surgeons; random sample of 950 cardiothoracic and cardiovascular surgical PAs; 1600 NPs identified with an interest in cardiology and/or surgery on their profiles.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**5.00**	10.00	110.00
Survey RVW:	2.00	3.75	**4.53**	7.00	15.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	30.00	**35.00**	50.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	33509	**Recommended Physician Work RVU: 3.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
34834	ZZZ	2.65	**RUC Time**

CPT Descriptor Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addtion to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
34716	ZZZ	7.19	**RUC Time**

CPT Descriptor Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addtion to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 21.4 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 15.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 33509	Top Key Reference CPT Code: 34834	2nd Key Reference CPT Code: 34716
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	35.00	30.00	72.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**35.00**	**30.00**	**72.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	11%	28%	39%	22%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	39%	33%	28%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	22%	78%

Physical effort required	11%	39%	50%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	39%	44%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	46%	31%	23%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	46%	38%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	38%	54%
Physical effort required	8%	38%	54%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	38%	62%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Tab 9 includes 2 codes that represent harvest of an upper extremity artery, typically the radial artery, that is used as an arterial conduit for coronary artery bypass grafting (CABG). Code 35600 is for harvest of an upper extremity artery using an open technique and the new code 33509 is for harvest of an upper extremity artery using an endoscopic technique. Endoscopic harvest of the upper extremity represents a new technology that is currently reported using the unlisted cardiac surgery code (33999), the unlisted vascular surgery code (37799) or the unlisted vascular endoscopy code (37501).

The radial artery is typically used in situations where a patient is undergoing a re-operative CABG procedure where the intrathoracic arteries have already been used and/or in patients with limited saphenous vein conduit available due to prior use in peripheral vascular disease operations or use in a previous CABG procedure. Recent emerging studies appear to indicate that use of radial-artery grafts for coronary-artery bypass grafting (CABG) may result in better postoperative outcomes than the use of saphenous-vein grafts. As a result of these circumstances, use of the radial artery in CABG has been increasing. Originally the radial artery was harvested using an open technique, but with technological advances, it is now possible to harvest the radial artery using an endoscopic technique and this method of harvest, where available, is now the preferred method for harvesting the radial artery.

Existing code 35600 was originally developed as an add-on code since the radial artery is typically only harvested for use in conjunction with an arterial CABG procedure. Over the years, in order to streamline CABG procedures, the radial artery conduit is typically harvested simultaneously while other conduits are also being harvested. The radial artery harvest may be performed by the surgeon performing the CABG procedure or an assistant at surgery, who may be another physician, an APP *(Advanced Practice Provider – a commonly used nomenclature for Physician Assistant (PA) or Nurse Practitioner (NP)).* The individual harvesting the radial artery may be the 1st assistant at surgery, but more typically it is an MD or APP other than the primary surgeon or 1st assistant at surgery who separately harvests the peripheral arterial and venous conduits for the CABG procedures. Since the upper extremity artery harvest procedures have evolved in this manner, the specialty societies felt that it would be more appropriate to designate the codes as modifier -51 exempt with XXX global periods. This along with surveying the codes as ZZZ global period procedures allows for the codes to be valued only for the intraoperative portion of the work since the procedures are almost exclusively performed in conjunction with an arterial CABG procedure (33533 – 33536). Reclassifying 35600 and assigning code 33509 as XXX global codes (as opposed to its previous ZZZ global classification), with a -51 modifier exempt status and valuing the codes as ZZZ global procedures allows the individual that performs the radial artery harvest to report it under their NPI, which will allow for appropriate tracking and reimbursement for the upper extremity artery harvest procedures. Any preoperative and postoperative care associated with the upper extremity artery harvest is typically included in the global period of the CABG procedure with the primary surgeon providing any associated pre and post-operative care related to the upper extremity artery harvest, including postoperative care of the surgical incision site. The provider that harvests the upper extremity artery is often involved in the patient's overall care as part of the cardiac surgery/heart team. Any associated care related to the upper extremity artery harvest generally falls under the global surgical period associated with the arterial CABG procedure. Based on these factors, the two upper extremity artery harvest codes were assigned an XXX global period, but were surveyed as ZZZ global procedures accounting for only the intra-operative time associated with the procedures. Since the procedures account for the intra-operative time only, there are no direct practice expense inputs for the procedures.

33509

Intensity and complexity of the procedure: 84 surveys were completed by a random sample of U.S. self-identified cardiac surgeons, cardiothoracic and cardiovascular surgical PAs and NPs identified with interest in cardiology and/or surgery on their profiles. Eighteen (21%) respondents selected code 34834 *Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)* as a reference code making it the 1st key reference service (KRS). The expert panel notes that there is a substantial work difference between open exposure of part of an artery for the introduction of an endovascular device and complete endoscopic dissection and resection of a long segment of artery for eventual transposition. That 1st KRS code has a lower value, and a shorter intraservice and total time than the survey code. The survey respondents ranged in their intensity/complexity comparison saying that the survey code 33509 was identical (28%), somewhat more (39%) or much more (22%) for the overall complexity measures and much more complex than the 1st KRS code for all of the intensity/complexity measures with the exception of mental effort and judgement, which ranged from less to more complex. Thirteen (15%) respondents selected code 34716 *Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)* as a reference code making it the 2nd KRS. This code has a higher value and a higher intraservice and total service time than the survey code. The respondents ranged in their intensity/complexity comparison saying that the overall intensity/complexity of the survey code 33509 is identical (46%), somewhat more (31%), or much more (23%) complex than the 2nd KRS code. For the other intensity/complexity measures the respondents indicated that the survey code was more complex for the technical skill/physical effort and psychological stress measures and identical to more complex for the mental effort and judgement measure than the 2nd KRS code.

Recommended RVW: The survey data for code 33509 (endoscopic upper extremity artery harvest) shows that the median intra-operative time is 35 minutes. The 25th percentile RVW from the survey was 3.75 and the median RVW from the survey was 4.53. The Expert Panel reviewed the survey data and are recommending the 25th percentile RVW of 3.75 and the median intra-service time of 35 minutes and an IWPUT of 0.107. The 1st KRS has a shorter intraservice time and lower RVW than the survey code with an IWPUT of 0.088. The 2nd KRS has a higher RVW and a longer intraservice and total time than the survey code with an IWPUT of 0.100. While the expert panel feels that the endoscopic code should have a longer intraservice time than the open code (35600), the survey data does not support this difference. The Expert Panel assumes that this may be due to the fact that the technology has been around long enough that those practitioners who most commonly perform the procedure are beginning to overcome

the learning curve, which is reflected in lower intra-service times for the procedure. The survey respondents indicated that the survey code was more or much more complex than all of the intensity/complexity measures for the 1st key reference service (KRS) for all but the mental effort and judgement, for which they indicated that the intensity/complexity of the survey code was less or identical to the 1st KRS. The 2nd KRS represents a procedure where the axillary or subclavian artery is exposed and a graft is sewn onto the exposed artery to create a conduit to facilitate cardiopulmonary bypass or delivery of an endovascular prosthesis. At completion of the procedure the graft is resected and the resulting arteriotomy is oversewn. The survey code represents a procedure where a segment of the radial artery is harvested endoscopically. This requires careful consideration to avoid injury of the surrounding neural and vascular tissues. In addition, there are numerous arterial branches that must be identified and clipped to achieve hemostasis after the artery is harvested and prevent catastrophic postoperative bleeding from the implanted conduit. The same considerations are not required for either of the KRS codes since there is no extensive arterial mobilization, dissection or resection involved in those procedures and no surgical maneuvers to ensure branch artery ligation/hemostasis. The survey respondents indicated that the intensity/complexity of the survey code was more complex than the 2nd KRS for most of the measures.

The Expert Panel is recommending the 25th percentile work RVW of 3.75, with a median intra-service time of 35 minutes, and total time of 35 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This procedure is valued as an add-on code, but it is desiganged as an XXX global because the procedure is typically performed by an NP or PA (typically from the same practice). The upper extremity artery is harvested by the NP/PA simultaneously with the surgeon performs the sternal approach. There may be another MD/PA/NP that acts as a 1st assistant at surgery for the rest of the case. The follow-up care for the entire procedure, including the post-op care for the upper extremity artery harvest, is provided by the surgeon.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	CPT	Desc	global	work rvu	pre time	intra time	post time	Tot tim
3.	33533	CABG 1 artery	090	33.75	95	158	429	682
4.	33530	Reop CABG	ZZZ	10.13		70	42.4	112.4
5.	33518	CABG 2 Vein	ZZZ	7.93		50	62.6	112.6
6.	33508	EVH	ZZZ	0.31		10		10
7.	33509	Endo UEAH	XXX	3.75		35		35
8.	Total			55.87	95	323	534	952

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33999, 37501 or 37799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiothoracic Surgery How often? Commonly

Specialty Physician Assistant How often? Commonly

Specialty Nurse Praticitioner How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 2834
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the 2019 RUC database there were 66,673 arterial CABG procedures performed. A recent report indicates that the rate of use the radial artery for grafting in the United States is 6.5%. A meta-analyis of six radial artery harvest studies was performed indicating that 43.6% of the radial arteries are harvested endoscopically and 56.4% are harvested using an open technique.

It is estimated that 2/3 of the total CABG procedures per year are performed for Medicare patients, so the estimated number of radial artery harvest procedures peformed natinally is 6501. Of those, 3666 will be performed using an open technique and 2834 of them will be perfromed endoscopically

Specialty Cardiothoracic Surgery Frequency 992 Percentage 35.00 %

Specialty Physician Assistant Frequency 993 Percentage 35.03 %

Specialty Nurse Praticitioner Frequency 849 Percentage 29.95 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,890
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the 2019 RUC database there were 66,673 arterial CABG procedures performed. A recent report indicates that the rate of use the radial artery for grafting in the United States is 6.5%. A meta-analyis of six radial artery harvest studies was performed indicating that 43.6% of the radial arteries are harvested endoscopically and 56.4% are harvested using an open technique.

The estimated number of radial artery harvest procedures peformed for Medicare is 4334. Of those, 2444 will be performed using an open technique and 1890 of them will be perfromed endoscopically.

Specialty Cardiothoracic Surgery Frequency 662 Percentage 35.02 %

Specialty Physician Assistant Frequency 663 Percentage 35.07 %

Specialty Nurse Praticitioner Frequency 565 Percentage 29.89 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-CABG

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 35600

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:35600 Tracking Number B2 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: XXX Current Work RVU: **4.94** RUC Recommended RVU: **4.00**

CPT Descriptor: Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, open

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old male presents to the emergency room with unstable angina. He has history of CABG. Cardiac catheterization reveals multivessel disease requiring several grafts. He is an acceptable candidate for re-operation CABG. Saphenous vein conduit is limited because of prior CABG and only a small segment available. The right internal mammary artery is available, the left radial artery in this right-handed individual is evaluated and appropriate for open harvesting and use for coronary artery bypass grafting.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The decision to utilize the radial artery as a conduit for CABG is made by the primary surgeon, typically during the initial visit with the patient. The primary surgeon performing the CABG obtains a history with attention given to conditions which may mitigate against using the radial such as renal failure requiring or likely to require dialysis, severe PVD or history of Reynaud syndrome. The arm and hand are examined and an Allen's test is performed to assess adequacy of the ulnar circulation and the palmar arch. An oxygen saturation monitor is also employed if available to assess the circulation provided by the ulnar artery.

At the time of CABG procedure (reported separately), the radial artery is checked in the operating room by the provider who will be harvesting the artery. An Allen's test utilizing the oxygen saturation monitor is performed to assess adequacy of the ulnar circulation and the palmar arch. Any abnormalities or concerns are discussed with the primary surgeon and a decision is made to proceed with harvest. The radial artery is typically harvested simultaneously while other conduits are also being harvested. A continuous intravenous nitroglycerin infusion is begun to prevent spasm of the radial artery. The radial artery is harvested simultaneously by making a curvilinear incision at the edge of the hairline of the left forearm following the brachioradialis muscle lateral to the biceps tendon and down to a midway point between the tendon of the flexor carpi radialis muscle and the radial styloid at the wrist crease. Hemostasis is obtained using a Bovie needle coagulator or a harmonic scalpel and dissection continues being careful to avoid nerves and larger vessels. The fascia between the bellies of the brachioradialis and flexor carpi radialis muscle is then divided. The radial artery is visualized and dissected beginning at the middle of the forearm proximally with the venous vascular pedicle kept intact. The vasa vasorum of the radial artery are then divided posteriorly using the harmonic scalpel or silk sutures proximally and metallic clips distally. As the dissection approaches the wrist, there are usually numerous small vessels that required meticulous identification and separation. Pulse oximetry on the thumb is rechecked. Before dividing the radial artery, a soft non-occluding clamp is placed across the dissected but still intact radial artery and palpation of the ulnar artery is performed to be certain that there is adequate blood supply to the hand. Only after adequacy of ulnar artery flow is confirmed, is the radial artery pedicle ligated and divided. The wound is inspected for hemostasis and the artery is ligated and divided. The fascia and subcutaneous tissues throughout the length of the forearm incision are closed in two layers using absorbable

sutures. The entire forearm skin incision is closed by a subcuticular method using monofilament absorbable sutures. The hand is checked for warmth and circulation is assessed with an oxygen saturation monitor. The arm is wrapped and a methylene blue marking pen is used to score the artery on its anterior surface so as maintain orientation of the radial artery conduit without inadvertent twisting. The radial artery is soaked and flushed with papaverine and heparinized patient blood. The entire length of the radial artery is checked while flushing it with the heparinized blood and branches are carefully clipped or tied per routine.

The primary surgeon uses the radial artery to bypass the designated coronary. The primary surgeon evaluates the radial artery harvest site at the end of the procedure.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	James Levett, MD (STS); Stephen Lahey, MD; (AATS); Joseph Turek, MD (STS); Jacob Schroder, MD (STS); Francis Nichols, MD (STS); Prashanath Vallabhajosyula. MD (STS); Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA (ANA); Folusho Ogunfiditimi, PA (AAPA)					
Specialty Society(ies):	AAPA; AATS; ANA; STS					
CPT Code:	35600					
Sample Size:	3991	**Resp N:**	72			
Description of Sample:	Random sample of 1441 US self-identified cardiac surgeons; random sample of 950 cardiothoracic and cardiovascular surgical PAs; 1600 NPs identified with an interest in cardiology and/or surgery on their profiles.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	10.00	400.00
Survey RVW:	2.00	4.00	**5.45**	7.00	18.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	30.00	**40.00**	56.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	35600	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
34834	ZZZ	2.65	**RUC Time**

CPT Descriptor Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
34715	ZZZ	6.00	**RUC Time**

CPT Descriptor Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 **% of respondents:** 19.4 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 15.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 35600	Top Key Reference CPT Code: 34834	2nd Key Reference CPT Code: **34715**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	40.00	30.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**40.00**	**30.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	14%	7%	57%	21%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	21%	29%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	7%	93%
Physical effort required	14%	14%	71%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	50%	43%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	9%	27%	55%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	45%	45%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	9%	45%	45%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	36%	64%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Tab 9 includes 2 codes that represent harvest of an upper extremity artery, typically the radial artery, that is used as an arterial conduit for coronary artery bypass grafting (CABG). Code 35600 is for harvest of an upper extremity artery using an open technique and the new code 33509 is for harvest of an upper extremity artery using an endoscopic technique. Endoscopic harvest of the upper extremity represents a new technology that is currently reported using the unlisted cardiac surgery code (33999), the unlisted vascular surgery code (37799) or the unlisted vascular endoscopy code (37501).

The radial artery is typically used in situations where a patient is undergoing a re-operative CABG procedure and in patients where the intrathoracic arteries have already been used and/or in patients with limited saphenous vein conduit available due to prior use in peripheral vascular disease operations or use in a previous CABG procedure. Recent emerging studies appear to indicate that use of radial-artery grafts for coronary-artery bypass grafting (CABG) may result in better postoperative outcomes than the use of saphenous-vein grafts. As a result of these circumstances, use of the radial artery in CABG has been increasing. Originally the radial artery was harvested using an open technique, but with technological advances, it is now possible to harvest the radial artery using an endoscopic technique and this method of harvest, where available, is now the preferred method for harvesting the radial artery.

Existing code 35600 was originally developed as an add-on code since the radial artery is typically only harvested for use in conjunction with an arterial CABG procedure. Over the years, in order to streamline CABG procedures, the radial artery conduit is typically harvested simultaneously while other conduits are also being harvested. The radial artery harvest may be performed by the surgeon performing the CABG procedure or an assistant at surgery, who may be another physician or an APP (Advanced Practice Provider – a commonly used nomenclature for Physician Assistant (PA) or Nurse Practitioner (NP)). The individual harvesting the radial artery may be the 1st assistant at surgery, but more typically is an MD or APP other than the primary surgeon or 1st assistant who separately harvests the peripheral arterial and venous conduits for the CABG procedures. Since the upper extremity artery harvest procedures have evolved in this manner, the specialty societies felt that it would be more appropriate to designate the codes as modifier -51 exempt with XXX global periods. This along with surveying the codes as ZZZ global period procedures allows for the codes to be valued only for the intraoperative portion of the work since the procedures are almost exclusively performed in conjunction with an arterial CABG procedure (33533 – 33536). Reclassifying 35600 and assigning code 33509 as XXX global codes (as opposed to its previous ZZZ global classification), with a -51 modifier exempt status and valuing the codes as ZZZ global procedures allows the individual that performs the radial artery harvest to report it under their NPI, which will allow for appropriate tracking and reimbursement for the upper extremity artery harvest procedures. Any preoperative and postoperative care associated with the upper extremity artery harvest is typically included in the global period of the CABG procedure with the primary surgeon providing any associated pre and post-operative care related to the upper extremity artery harvest, including postoperative care of the surgical incision site. The provider that harvests the upper extremity artery is often involved in the patient's overall care as part of the cardiac surgery/heart team. Any associated care related to the upper extremity artery harvest generally falls under the global surgical period associated with the arterial CABG procedure. Based on these factors, the two upper extremity artery harvest codes were assigned an XXX global period, but were surveyed as ZZZ global procedures accounting for only the intra-operative time associated with the procedures. Since the procedures account for the intra-operative time only, there are no direct practice expense inputs for the procedures.

35600

Intensity and complexity of the procedure: 72 surveys were completed by a random sample of U.S. self-identified cardiac surgeons, cardiothoracic and cardiovascular surgical PAs and NPs identified with interest in cardiology and/or surgery on their profiles. Fourteen (19%) respondents selected code 34834 *Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)* as a reference code making it the 1st key reference service (KRS). The expert panel notes that there is a substantial work difference between open exposure of part of an artery for the introduction of an endovascular device and complete dissection and resection of a long segment of artery for eventual transposition. The 1st key reference has a lower value, and a shorter intraservice and total time than the survey code. The survey respondents ranged in their intensity/complexity comparison saying that the overall survey code 35600 was somewhat more (57%) or much more (21%) complex than 1st KRS code, more complex for the other intensity/complexity measures and identical to more for psychological stress. Eleven (15%) respondents selected code 34715 *Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)* as a reference code making it the 2nd KRS. This code has a higher value with longer intraservice and total service times then the survey code. The respondents ranged in their overall intensity/complexity comparison saying that the survey code is identical (27%) or somewhat more (55%) complex than the 2nd KRS code more complex for technical skill and psychological stress measures and identical or more complex for the mental effort/judgement and physical effort measures.

Recommended RVW: The survey data for code 35600 (open upper extremity artery harvest) shows that the median intra-operative time is 40 minutes. The current intra-service time for this procedure is 40 minutes. The current RVW for the code is 4.94. The 25th percentile RVW from the survey was 4.00 and the median RVW from the survey was 5.45. The Expert Panel reviewed the data recognizing that there was no change in intra- service work from the current time and determined that there is no compelling evidence to support an increase in the RVW.

Although there is no change in time for the procedure, the Expert Panel recognizes that the fee schedule has changed since the code was last valued in 2000 and as such, to maintain relativity across the fee schedule, the Expert Panel is recommending the current work RVW of 4.94 be reduced to 4.00, which represents the 25th percentile from the survey resulting in a decrease in value for the same intra-service and total time of 40 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) This procedure is valued as an add-on code, but it is desiganged as an XXX global because the procedure is typically performed by an NP or PA (typically from the same practice). The upper extremity artery is harvested by the NP/PA simultaneously with the surgeon who performs the sternal approach. There may be another MD/PA/NP that acts as a 1st assistant at surgery for the rest of the case. The follow-up care for the entire procedure, including the post-op care for the upper extremity artery harvest, is provided by the surgeon.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT	Desc	global	work rvu	pre time	intra time	post time	Tot time
4.	33533	CABG 1 artery	090	33.75	95	158	429	682
5.	33530	Reop CABG	ZZZ	10.13		70	42.4	112.4
6.	33518	CABG 2 Vein	ZZZ	7.93		50	62.6	112.6
7.	33508	EVH	ZZZ	0.31		10		10
8.	35600	ORAH	XXX	4.00		40		40
9.	Total			56.12	95	328	534	957

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 35600

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiothoracic Surgery — How often? Commonly

Specialty Physician Assistant — How often? Commonly

Specialty Nurse Praticitioner — How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 3366
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the 2019 RUC database there were 66,673 arterial CABG procedures performed. A recent report indicates that the rate of use the radial artery for grafting in the United States is 6.5%. A meta-analyis of six radial artery harvest studies was performed indicating that 43.6% of the radial arteries are harvested endoscopically and 56.4% are harvested using an open technique.

It is estimated that 2/3 of the total CABG procedures per year are performed for Medicare patients, so the estimated number of radial artery harvest procedures peformed natinally is 6501. Of those, 3666 will be performed using an open technique and 2834 of them will be perfromed endoscopically.

Specialty Cardiothoracic Surgery	Frequency 1178	Percentage 34.99 %
Specialty Physician Assistant	Frequency 1179	Percentage 35.02 %
Specialty Nurse Praticitioner	Frequency 1009	Percentage 29.97 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,444
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on the 2019 RUC database there were 66,673 arterial CABG procedures performed. A recent report indicates that the rate of use the radial artery for grafting in the United States is 6.5%. A meta-analyis of six radial artery harvest studies was performed indicating that 43.6% of the radial arteries are harvested endoscopically and 56.4% are harvested using an open technique.

The estimated number of radial artery harvest procedures peformed for Medicare is 4334. Of those, 2444 will be performed using an open technique and 1890 of them will be perfromed endoscopically.

Specialty Cardiothoracic Surgery	Frequency 855	Percentage 34.98 %
Specialty Physician Assistant	Frequency 856	Percentage 35.02 %
Specialty Nurse Praticitioner	Frequency 733	Percentage 29.99 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-CABG

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 35600

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Harvest of Upper Extremity Artery
TAB: 9

Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th
1st REF	34834	ZZZ	Open brachial artery exposure for d	18	0.088		
2st REF	34716	ZZZ	Open axillary/subclavian artery exp	13	0.100		
SVY	33509	XXX	Harvest of upper extremity artery, 1	84	0.129	2.00	3.75
REC 25th	33509	XXX	Harvest of upper extremity artery, 1		0.107		

Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th
1st REF	34834	ZZZ	Open brachial artery exposure for d	14	0.088		
2nd REF	34715	ZZZ	Open axillary/subclavian artery exp	11			
CURRENT	35600	ZZZ	Harvest of upper extremity artery, 1		0.124		
SVY	35600	XXX	Harvest of upper extremity artery, 1	72	0.136	2.00	4.00
REC 25th	35600	XXX	Harvest of upper extremity artery, 1		0.100		

Breakout by specialty

AAPA

Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th
1st REF	33987	ZZZ	Arterial exposure with creation of g	3	0.090		
2st REF	34833	ZZZ	Open femoral artery exposure with	3	0.101		
SVY	33509	XXX	Harvest of upper extremity artery, 1	18	0.083	2.50	3.00

AATS/STS

Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th
1st REF	34834	ZZZ	Open brachial artery exposure for d	15	0.088		
2st REF	34716	ZZZ	Open axillary/subclavian artery exp	11	0.100		
SVY	33509	XXX	Harvest of upper extremity artery, 1	65	0.167	2.00	4.00

ANA

Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th
SVY	33509	XXX	Harvest of upper extremity artery, 1	1	0.300	0.00	0.00

AAPA

Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th
1st REF	34834	ZZZ	Open brachial artery exposure for d	5	0.088		
2nd REF	99358	XXX	Prolonged evaluation and managem	3	0.035		

CURRENT	35600	ZZZ	Harvest of upper extremity artery, 1		0.124		
SVY	35600	XXX	Harvest of upper extremity artery, 1	18	0.081	2.00	3.00

AATS/STS

Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th
1st REF	34834	ZZZ	Open brachial artery exposure for d	9	0.088		
2nd REF	34715	ZZZ	Open axillary/subclavian artery exp	9			
CURRENT	35600	ZZZ	Harvest of upper extremity artery, 1		0.124		
SVY	35600	XXX	Harvest of upper extremity artery, 1	53	0.143	2.00	4.25

ANA

Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th
SVY	33509	XXX	Harvest of upper extremity artery, 1	1	0.367	0.00	0.00

RVW			Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPI		
MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED
2.65			30						30						
7.19			72						72						
4.53	7.00	15.00	35				5	30	35	50	90		0	1	5
3.75			35						35						

RVW			Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPI		
MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED
2.65			30						30						
6.00			60						60						
4.94			40						40						
5.45	7.00	18.00	40				5	30	40	56	120		0	0	5
4.00			40						40						

RVW			Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPI		
MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED
4.04			45						45						
5.25			52						52						
4.16	6.38	9.00	50				30	45	50	60	90		0	1	6

RVW			Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPI		
MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED
2.65			30						30						
7.19			72						72						
5.00	7.00	15.00	30				5	30	30	45	75		0	1	5

RVW			Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPI		
MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED
4.50	0.00	0.00	15				0	0	15	0	0		0	0	0

RVW			Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPI		
MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED
2.65			30						30						
2.10			60						60						

4.94			40				40					
4.04	6.00	9.50	50		25	35	50	60	120		0	0	5

RVW			Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXP		
MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED
2.65			30						30						
6.00			60						60						
4.94			40						40						
5.70	7.10	18.00	40				5	25	40	48	75		0	0	5

RVW			Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXP		
MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED
5.50	0.00	0.00	15				0	0	15	0	0		0	0	0

ERIENCE	
75th	MAX
10	110

ERIENCE	
75th	MAX
10	400

ERIENCE	
75th	MAX
10	75

ERIENCE	
75th	MAX
10	110

ERIENCE	
75th	MAX
0	0

ERIENCE	
75th	MAX

11	75

ERIENCE	
75th	MAX
10	400

ERIENCE	
75th	MAX
0	0

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

December 13, 2020

RE: Tab 6 Practice Expense

Dear Dr. Manaker:

Tab 9 on the January 2021 RUC agenda addresses two XXX global codes for open and endoscopic upper extremity artery harvest that were valued as add-on codes. These two codes are typically only performed with arterial CABG procedures. Any pre and postoperative work associated with these procedures are accounted for in the work/ practice expense of the arterial CABG procedures. Both procedures are provided exclusively in the facility setting. As such, we recommend no direct practice expense inputs for Tab 9.

Thank you for your consideration of this information as you prepare for the meeting. Please contact Julie Painter at jpainter@physiciancoding.com if you have any questions.

Sincerely,
James M. Levett, MD
STS RUC Advisor

Stephen J. Lahey, MD
AATS RUC Advisor

Folusho Ogunfiditimi, PA-C
AAPA RUC Advisor

Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA
ANA RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Drug Induced Sleep Endoscopy (DISE) – Tab 10

In October 2020, the CPT Editorial Panel created one new code to report drug induced sleep endoscopy (DISE) flexible, diagnostic.

42975 Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx, tongue base, and largynx for evaluation of sleep disordered breathing; flexible, diagnostic

The RUC reviewed the survey results from 148 otolaryngologists and determined that the survey 25th percentile work RVU of 1.90 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 18 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 6 minutes of pre-service scrub/dress/wait time, 15 minutes of intra-service time, and 28 minutes of immediate post-service time.

To justify the 28 minutes of immediate post-service time, the specialty society explained that the typical patient has significant sleep apnea and has had their airway manipulated. After receiving sedation and scoping of the upper airway, the airway is no longer secure and must be monitored. Often patients must be monitored closely following the procedure until the patient is discharged from the hospital. Nonetheless, physician work continues outside of the immediate post-operative time for potentially increased swelling and/or because the patient's sedation has not worn-off. However, the RUC questioned the ½ discharge day management (99238), resulting from the specialty society using a 000-day global instrument with post-operative visits to value the service. The RUC agreed that the 000-day global survey instrument with post-operative visits is not typical and is dedicated for services that require more significant hospital stay. After thorough discussion, the RUC agreed that a ½ discharge day management (99238) is not necessary for this service. By surveying the incorrect 000-day global survey instrument, survey respondents underestimated the immediate post-service time estimates. The RUC agreed with an immediate post-service time of 28 minutes with the understanding that there is time value related to the ½ discharge day management originally recommended by the specialty society and agreed that post-service time package (8b) of 28 minutes is justified. The RUC requested that this service be valued as interim and be resurveyed for the April 2021 RUC meeting using a standard 000-day global survey instrument (*without* post-operative visits).

The RUC compared the survey code to code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 1.90 and intra-service time of 15 minutes) and noted that both codes have identical intra-service time and should be valued identically. Additionally, the RUC compared the survey code to MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU= 1.90 and intra-service time of 15 minutes) and noted that both codes require the same amount of physician work and intra-service time, further warranting a value of 1.90. **The RUC recommends an interim work RVU of 1.90 for CPT code 42975.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

RUC Database Flag
The RUC recommends to flag CPT code 42975 as "do not use to validate for physician work" since the RUC is recommending an interim work RVU for this service and will be resurveyed for the April 2021 RUC meeting.

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty society.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Respiratory System** **Larynx** **Endoscopy**				
31575		*Laryngoscopy, flexible; diagnostic* *(Do not report 31575 in conjunction with 31231, unless performed for a separate condition using a separate endoscope)* (Do not report 31575 in conjunction with 31572, 31573, 31574, 31576, 31577, 31578, 42975, 43197, 43198, 92511, 92612, 92614, 92616)		
Digestive System **Pharynx, Adenoids, and Tonsils**				
Other Procedures				
●42975	M1	Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic (Do not report 42975 in conjunction with 31575, 92511) (Do not report 42975 in conjunction with 31231, unless performed for a separate condition [ie, other than sleep disordered breathing] and using a separate endoscope)	000	1.90 (Interim RUC Recommendation) (Resurvey for April 2021)
Medicine **Special Otorhinolaryngologic Services**				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

92511	*Nasopharyngoscopy with endoscope (separate procedure)* (Do not report 92511 in conjunction with 31575, 42975, 43197, 43198) *(For nasopharyngoscopy, surgical, with dilation of eustachian tube, see 69705, 69706)*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:42975 Tracking Number Original Specialty Recommended RVU: **2.19**
Presented Recommended RVU: **2.19**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **1.90**

CPT Descriptor: Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx, tongue base, and largynx for evaluation of sleep disordered breathing; flexible, diagnostic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year old male with moderate to severe obstructive sleep apnea has been unable to tolerate positive airway pressure therapy, sleep endoscopy is performed to identify anatomic and physiologic factors contributing to his obstructive sleep apnea and the selection of non-continuous positive airway pressure (cpap) treatment options

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 64% , In the ASC 35%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 81% , Overnight stay-less than 24 hours 18% , Overnight stay-more than 24 hours 1%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 94%

Description of Pre-Service Work: Meet with patients and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam. Reconcile medications and allergies. Address NPO status and timing. Discuss the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common complications. Discussion with the anesthesiologist regarding the level of sedation required and the approximate length of the case. Review and obtain informed consent. The availability of all required instruments and supplies is verified. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The patient is positioned. The surgeon scrubs, gowns and preps the patient for the procedure.

Description of Intra-Service Work: The nasal passages are prepared with application of a decongestant and/or topical anesthesia. Light intravenous sedation is given, which typically is provided by a separate provider, to a point where the patient is non-responsive to verbal stimuli, has snoring or partial upper airway flow limitation, and observed oxygen desaturations. The performing physician then places a flexible endoscope through the nose and advances it to the pharynx. Endoscopic evaluation of the nasopharynx, oropharynx, hypopharynx, and larynx is performed during sleep or sedation over multiple cycles of airway narrowing and/or obstruction. The velopharynx is the term for the distal (no muscular) component of the soft palate and uvula. This is the predominant site of upper pharyngeal collapse. The physician will note the anatomic site of obstruction (velopharynx, oropharynx, tongue, epiglottis), the severity of the obstruction (non, partial, complete), and pattern of obstruction (anteroposterior, circular, lateral).The physician then repositions the patient and/or performs manipulation of the head and neck and repeat endoscopy to determine effect of body position (supine versus lateral); jaw lift, tongue protrusion, or hyoid lift on airway obstruction. A patient’s existing oral appliance (mandibular advancement device) is placed and titrated to optimal effect. In certain cases, a continuous positive airway pressure (CPAP) mask may be applied to determine sites on ongoing obstruction in regular CPAP users who fail to improve with CPAP therapy.

Description of Post-Service Work: The patient is observed during emergence from anesthesia. The procedure is dictated. Discharge medications are reconciled. The prescription drug monitoring database is reviewed. Postoperative orders, medications and instructions are written. There is a discussion with the family and patient regarding the procedure and findings. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course,

signs and symptoms of complications, and review of the written postoperative instructions. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	42975					
Sample Size:	3963	**Resp N:**	148			
Description of Sample:	Targeted Random Sample					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	6.00	**15.00**	37.00	300.00	
Survey RVW:	0.20	1.90	**2.19**	2.59	100.00	
Pre-Service Evaluation Time:			**20.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**6.00**			
Intra-Service Time:	1.00	10.00	**15.00**	20.00	45.00	

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	42975	**Recommended Physician Work RVU: 1.90**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**18.00**	**18.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

8B IV Sedation/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**28.00**	**28.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31579	000	1.88	**RUC Time**

CPT Descriptor Laryngoscopy, flexible or rigid telescopic, with stroboscopy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31575	000	0.94	**RUC Time**

CPT Descriptor Laryngoscopy, flexible; diagnostic

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64479	000	2.29	**RUC Time**	7,531,319

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
31577	000	2.19	**RUC Time**

CPT Descriptor
Laryngoscopy, flexible; with removal of foreign body(s)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 42 **% of respondents:** 28.3 **%**

Number of respondents who choose 2nd Key Reference Code: 21 **% of respondents:** 14.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 42975	Top Key Reference CPT Code: 31579	2nd Key Reference CPT Code: **31575**
Median Pre-Service Time	25.00	14.00	14.00
Median Intra-Service Time	15.00	10.00	5.00
Median Immediate Post-service Time	28.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**68.00**	**34.00**	**24.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	12%	71%	14%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	2%	31%	66%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	12%	55%	33%
Physical effort required	2%	73%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	29%	69%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	5%	0%	19%	52%	24%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	19%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	52%	43%
Physical effort required	5%	35%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	38%	55%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting new code 42975. The Panel approved the CCA and the code is now being valued by the RUC. The new code will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 3963 members from the American Academy of Otolaryngology – Head and Neck Surgery who self-designated as one or more of the following sub-specialties: General Otolaryngology, Sleep Medicine, or Pediatric Otolaryngology.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **1.90 and 15 minutes of intra service time**, based on our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 2 and post-time package 8B due to this procedure currently being done predominantly in the hospital outpatient setting using conscious sedation.

Pre-time Package 2 Difficult Patient / Straightforward Procedure (No anesthesia care)

Evaluation Time – We are recommending 18 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 1 minute of positioning time which is a decrease of 4 minutes from the median survey time, but consistent with the pre-service package time for this activity.

Scrub, Dress, Wait Time – We are recommending 6 minutes of scrub, dress and wait time which is identical to the pre-service package time, based on our survey median.

This results in a total recommended pre time of 25 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 8B IV Sedation/ Complex Procedure
Recommended time is 28 minutes to account for the survey's immediate post time of 10 minutes indicated by resopndents, but also the survey information that indicated a discharge management visit was typical (19 minutes is the time for a half day discharge management visit). The package post time is 28 minutes, so we felt this was appropriate given the survey post time plus a .5 DM visit would equate to 29 post minutes. All time for post work and patient post procedure monitoring was moved into the immediate post time and ***results in a total recommended immediate post time of 28 minutes, taking the lesser of surveyed time or the pre-service package time.***

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Pre Eval	Pre Positioning	Pre SDW	Intra	Post Time	Total Time	Most Recent RUC Review
69801	Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal	000	0.1003	2.06	12	1	5	15	10	43	2010-04
31577	Laryngoscopy, flexible; with removal of foreign body(s)	000	0.1053	2.19	13	1	9	15	10	48	2015-10
31573	Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral	000	0.1153	2.43	17	1	9	15	10	52	2015-10
31574	Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral	000	0.1108	2.43	20	1	9	15	10	55	2015-10
31578	Laryngoscopy, flexible; with removal of lesion(s), non-laser	000	0.1168	2.43	16	1	9	15	10	51	2015-10

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 31599

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 106858
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume predicted below, using the percentages of the three prior codes that were used to report the service.

Specialty Otolaryngology Frequency 106858 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 35,619 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This takes the percentage estimates of the three codes above which were previously used to report the service and adds the volume together that is anticipated in the new code.

Specialty Otolaryngology Frequency 35619 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Endoscopy

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31573

SS Rec Summary

ISSUE: Drug Induced Sleep Endoscopy

TAB: 10

								RVW						PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							SURVEY EXPERIENCE				
Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	MIN	25th	MED	75th	MAX
1st REF	31579	000	Laryngoscopy, flexible or rigid telescopic, with stroboscopy	42	0.141	0.055			1.88			34	8	1	5			10			10												
2nd REF	31575	000	Laryngoscopy, flexible; diagnostic	21	0.117	0.039			0.94			24	8	1	5			5			5												
CURRENT	NEW				#DIV/0!	#DIV/0!						0																					
SVY	42975		Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx,	148	0.048	0.029	0.20	1.90	2.19	2.59	100.00	75	20	5	6	1	10	15	20	45	10						0.5		0	6	15	37	300
REC	42975	000	Drug induced sleep endoscopy; with dynamic evaluation of velum, pharynx, tongue base, and largynx for evaluation of sleep disordered breathing; flexible, diagnostic		0.053	0.028			1.90			68	18	1	6			15			28												

FACILITY DIRECT PE INPUTS **CPT CODE(S):** 42975

SPECIALTY SOCIETY(IES): AAO-HNS

PRESENTER(S): R. Peter Manes, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
42975	Drug induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
42975	A 45-year old male with moderate to severe obstructive sleep apnea has been unable to tolerate positive airway pressure therapy, sleep endoscopy is performed to identify anatomic and physiologic factors contributing to his obstructive sleep apnea and the selection of non-continuous positive airway pressure (cpap) treatment options

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialty formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisor and multiple clinical experts who practice in the areas of general otolaryngology, sleep medicine and pediatric otolaryngology. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   42975 is a new CPT code, therefore, reference code 31576 was selected. The reference code was chosen based on the fact that it was recently valued by the RUC by our specialty, and is also a 000 global service that is typically performed in the hospital outpatient setting.

3. Is this code(s) typically reported with an E/M service?

   No, however, a discharge management visit is typical based on the typical site of service being the hospital.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   We are recommending clinical staff pre-time above the standard for 000 globals of 0 minutes. This represents use of clinical staff of endoscopy per the PE Subcommittee standards and is consistent with what the PE approved in the January 2017 and January 2020 for otolaryngology services typically performed in the hospital setting. The rationale for this time is that staff are essential to scheduling, and completing paperwork necessary, to schedule these procedures in the facility setting. The recommendation for the new code is consistent with these recommendations and includes the standard time for clinical staff activities for endoscopy procedures time in the pre-service.

FACILITY DIRECT PE INPUTS **CPT CODE(S):** 42975

SPECIALTY SOCIETY(IES): AAO-HNS

PRESENTER(S): R. Peter Manes, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A, this is a new code. No new inputs are being requested / invoices provided.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

During the pre-service period the clinical staff are conducting the typical activities for endoscopy procedures, when performed in the facility setting. Those include: Completing pre-service diagnostic and referral forms Coordinating pre-surgery services (including test results) Scheduling the space and equipment in the facility Providing pre-service education and obtaining consent Completing pre-procedure phone calls and prescriptions

   b. Service period (includes pre, intra and post):

There are no clinical staff activities during the service period.

   c. Post-service period:

During the post-service period the clinical staff call the patient to check in and see how they're doing post-procedure. They also inquire about use of CPAP post procedure.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

No supplies, only making facility recommendations at this time.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

No supplies, only making facility recommendations at this time.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

No equipment, only making facility recommendations at this time.

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

No equipment, only making facility recommendations at this time.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):___42975_____**

SPECIALTY SOCIETY(IES):__AAO-HNS_____

PRESENTER(S):__R. Peter Manes, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A new code.

	A	B	D	E	F	G	H	I
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMM**
2						**CPT Code 31576**		**429**
3		***RUC Collaboration Website***				Laryngoscopy, flexible; with biopsy(ies)		Drug induced slee dynamic evaluation tongue base, and la of sleep disordered diagn
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 10 Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**			
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 136.05**	**$ 86.92**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**112.0**	**33.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**30.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**91.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 41.44**	**$ 12.21**	**$ -**
13		**PRE-SERVICE PERIOD**						
14		**Start: Following visit when decision for surgery/procedure made**						
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	5	5	
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37	3	10	
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37	0	5	
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	7	7	
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3	3	
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37			
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37			
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37			
23			L037D	RN/LPN/MTA	0.37			
26		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37			
29		**End: When patient enters office/facility for surgery/procedure**						
30		**SERVICE PERIOD**						
31		**Start: When patient enters office/facility for surgery/procedure:**						
32		**Pre-Service (of service period)**						
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37	3	0	
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5	0	
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37			
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37			
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	2	0	
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37			
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37	5	0	
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	2	0	
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37			
42			L037D	RN/LPN/MTA	0.37			
45		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37			
48		**Intra-service (of service period)**						
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)	L037D	RN/LPN/MTA	0.37	10	0	
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)	L037D	RN/LPN/MTA	0.37			
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)	L037D	RN/LPN/MTA	0.37			
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37			
55			L037D	RN/LPN/MTA	0.37			
56		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37			
59		**Post-Service (of service period)**						
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37	15	0	
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37			
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3	0	
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37	30	0	
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37	10	0	
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37	3	0	
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37			
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	3	0	
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L037D	RN/LPN/MTA	0.37			
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37			
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate imaging visit	L037D	RN/LPN/MTA	0.37			
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37			
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L037D	RN/LPN/MTA	0.37			
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37			
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**
75			L037D	RN/LPN/MTA	0.37			
78		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37			
81		**End: Patient leaves office/facility**						
82		**POST-SERVICE PERIOD**						
83		**Start: Patient leaves office/facility**						
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37	3	3	
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37			
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16					
88		99212 27 minutes	27					
89		99213 36 minutes	36					
90		99214 53 minutes	53					
91		99215 63 minutes	63					
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37			
96		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37			
99		**End: with last office visit before end of global period**						

	A	B	D	E	F	G	H	I
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMM**
2						**CPT Code 31576**		**429**
3		***RUC Collaboration Website***				Laryngoscopy, flexible; with biopsy(ies)		Drug induced slee dynamic evaluation tongue base, and la of sleep disordered diagn
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 10 Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**			
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 136.05**	**$ 86.92**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**112.0**	**33.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**30.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**91.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**				
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 74.71**	**$ 74.71**	**$ -**
102	SA041	pack, basic injection	10.755	pack		1		
103	SA048	pack, minimum multi-specialty visit	4.0507	pack		1		
104	SB012	drape, sterile, for Mayo stand	1.2245	item		1		
105	SB022	gloves, non-sterile	0.246	pair		1		
106	SC029	needle, 18-27g	0.0523	item		1		
107	SC057	syringe 5-6ml	0.135	item		1		
108	SD009	canister, suction	4.2095	item		1		
109	SD122	suction tip, Yankauer	0.5865	item		1		
110	SD132	tubing, suction, non-latex (6ft uou)	0.9212	item		2		
111	SD318	Disposable biopsy forceps	24.02	item		1		
112	SG056	gauze, sterile 4in x 4in (10 pack uou)	1.0995	item		1		
113	SH050	lidocaine 4% soln, topical (Xylocaine)	0.1733	ml		2		
114	SJ010	basin, emesis	0.2415	item		1		
115	SJ037	oxymetazoline nasal spray (Afrin) (15ml uou)	1.7025	item		1		
116	SJ053	swab-pad, alcohol	0.0333	item		2		
117	SK058	paper, photo printing (8.5 x 11)	0.7125	item		2		
118	SL036	cup, biopsy-specimen sterile 4oz	0.6433	item		1		
119	SL037	cup, medicine (1oz size)	0.009	item		1		
120	SM001	atomizer tip shield (RhinoGuard)	0.905	item		1		
121	SM010	cleaning brush, endoscope	3.6105	item		2		
122	SM014	endoscope anti-fog solution	0.8367	ml		2		
123	SM015	enzymatic detergent	0.2223	oz		4		
124	SM018	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	2.6212	oz		4		
125	SM019	glutaraldehyde test strips (Cidex, Metrex)	0.883	item		1		
126		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*						
128	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**			
129		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 19.90**	**$ -**	**$ -**
130	ES084	channeled flexible digital scope, laryngoscopy	18694.39	Scope	0.108312212	57	0	
131	ES031	scope video system (monitor, processor, digital capture, cart, printer, LED light)	53489.691	Scope Systems	0.202673463	30	0	
132	ES005	endoscope disinfector, rigid or fiberoptic, w-cart	27500	Default	0.086369514	30	0	
133	EQ234	suction and pressure cabinet, ENT (SMR)	4032.9248	Default	0.010702279	96	0	
134	EQ170	light, fiberoptic headlight w-source	3525.9372	Default	0.013970455	96	0	
135	EQ167	light source, xenon	10922.938	Default	0.043278824	30	0	
136	EQ137	instrument pack, basic ($500-$1499)	500	Instrument Packs	0.002323783	37	0	
137	EF015	mayo stand	524.793	Default	0.001167346	96	0	
138	EF008	chair with headrest, exam, reclining	5565.6015	Default	0.01238009	96	0	
139								
140								
141								
142		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*						

	A	B	J	K	L	M	N	O	P
1	**RUC Practice Expense Spreadsheet**		**ENDED**						
2			**75**						
3		***RUC Collaboration Website***	) endoscopy, with						
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 10** **Specialty: AAO-HNS**	of velum, pharynx, rynx for evaluation breathing, flexible, ostic						
5		**LOCATION**	**Facility**						
6		**GLOBAL PERIOD**	**000**						
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 8.14**						
8		**TOTAL CLINICAL STAFF TIME**	**22.0**						
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**19.0**						
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**						
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**						
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 8.14**						
13		**PRE-SERVICE PERIOD**							
14		**Start: Following visit when decision for surgery/procedure made**							
15	CA001	Complete pre-service diagnostic and referral forms	3						
16	CA002	Coordinate pre-surgery services (including test results)	5						
17	CA003	Schedule space and equipment in facility	3						
18	CA004	Provide pre-service education/obtain consent	5						
19	CA005	Complete pre-procedure phone calls and prescription	3						
20	CA006	Confirm availability of prior images/studies							
21	CA007	Review patient clinical extant information and questionnaire							
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)							
23									
26		*Other activity: please include short clinical description here and type new in column A*							
29		**End: When patient enters office/facility for surgery/procedure**							
30		**SERVICE PERIOD**							
31		**Start: When patient enters office/facility for surgery/procedure:**							
32		**Pre-Service (of service period)**							
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available							
34	CA010	Obtain vital signs							
35	CA011	Provide education/obtain consent							
36	CA012	Review requisition, assess for special needs							
37	CA013	Prepare room, equipment and supplies							
38	CA014	Confirm order, protocol exam							
39	CA015	Setup scope (nonfacility setting only)							
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient							
41	CA017	Sedate/apply anesthesia							
42									
45		*Other activity: please include short clinical description here and type new in column A*							
48		**Intra-service (of service period)**							
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (33%)							
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)							
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (>67%)							
52	CA021	Perform procedure/service---NOT directly related to physician work time							
55									
56		*Other activity: please include short clinical description here and type new in column A*							
59		**Post-Service (of service period)**							
60	CA022	Monitor patient following procedure/service, multitasking 1:4							
61	CA023	Monitor patient following procedure/service, no multitasking							
62	CA024	Clean room/equipment by clinical staff							
63	CA025	Clean scope							
64	CA026	Clean surgical instrument package							
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions							
66	CA028	Review/read post-procedure x-ray, lab and pathology reports							
67	CA029	Check dressings, catheters, wounds							
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page							
69	CA031	Review examination with interpreting MD/DO							
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate imaging visit							
71	CA033	Perform regulatory mandated quality assurance activity (service period)							
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)							
73	CA035	Review home care instructions, coordinate visits/prescriptions							
74	CA036	Discharge day management							
75									
78		*Other activity: please include short clinical description here and type new in column A*							
81		**End: Patient leaves office/facility**							
82		**POST-SERVICE PERIOD**							
83		**Start: Patient leaves office/facility**							
84	CA037	Conduct patient communications	3						
85	CA038	Coordinate post-procedure services							
86		***Office visits: List Number and Level of Office Visits***	**# visits**						
87		99211 16 minutes							
88		99212 27 minutes							
89		99213 36 minutes							
90		99214 53 minutes							
91		99215 63 minutes							
92	CA039	Post-operative visits (total time)	**0.0**						
93									
96		*Other activity: please include short clinical description here and type new in column A*							
99		**End: with last office visit before end of global period**							

	A	B	J	K	L	M	N	O	P
1	**RUC Practice Expense Spreadsheet**		**ENDED**						
2			**75**						
3		***RUC Collaboration Website***	) endoscopy, with						
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 10** **Specialty: AAO-HNS**	of velum, pharynx, rynx for evaluation breathing, flexible, ostic						
5		**LOCATION**	**Facility**						
6		**GLOBAL PERIOD**	**000**						
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 8.14**						
8		**TOTAL CLINICAL STAFF TIME**	**22.0**						
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**19.0**						
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**						
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**						
100	**Supply Code**	**MEDICAL SUPPLIES**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**						
102	SA041	pack, basic injection							
103	SA048	pack, minimum multi-specialty visit							
104	SB012	drape, sterile, for Mayo stand							
105	SB022	gloves, non-sterile							
106	SC029	needle, 18-27g							
107	SC057	syringe 5-6ml							
108	SD009	canister, suction							
109	SD122	suction tip, Yankauer							
110	SD132	tubing, suction, non-latex (6ft uou)							
111	SD318	Disposable biopsy forceps							
112	SG056	gauze, sterile 4in x 4in (10 pack uou)							
113	SH050	lidocaine 4% soln, topical (Xylocaine)							
114	SJ010	basin, emesis							
115	SJ037	oxymetazoline nasal spray (Afrin) (15ml uou)							
116	SJ053	swab-pad, alcohol							
117	SK058	paper, photo printing (8.5 x 11)							
118	SL036	cup, biopsy-specimen sterile 4oz							
119	SL037	cup, medicine (1oz size)							
120	SM001	atomizer tip shield (RhinoGuard)							
121	SM010	cleaning brush, endoscope							
122	SM014	endoscope anti-fog solution							
123	SM015	enzymatic detergent							
124	SM018	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)							
125	SM019	glutaraldehyde test strips (Cidex, Metrex)							
126		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
128	**Equipment Code**	**EQUIPMENT**							
129		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**						
130	ES084	channeled flexible digital scope, laryngoscopy							
131	ES031	scope video system (monitor, processor, digital capture, cart, printer, LED light)							
132	ES005	endoscope disinfector, rigid or fiberoptic, w-cart							
133	EQ234	suction and pressure cabinet, ENT (SMR)							
134	EQ170	light, fiberoptic headlight w-source							
135	EQ167	light source, xenon							
136	EQ137	instrument pack, basic ($500-$1499)							
137	EF015	mayo stand							
138	EF008	chair with headrest, exam, reclining							
139									
140									
141									
142		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*							

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Periurethral Balloon Continence Device Procedures – Tab 11

In October 2020, the CPT Editorial Panel replaced four CPT Category III codes (0548T, 0549T, 0550T, and 0551T) with four new CPT Category I codes (53451, 53452, 53453, 53454) to report periurethral adjustable balloon continence device. The RUC reviewed a letter from the American Urological Association that noted that these codes currently have low utilization and that only 65 physicians have been trained to perform these procedures; only 38 of those physicians have performed them. Given the low utilization and the low survey response rate (four completed survey responses), the specialty society recommended that CMS have the Medicare Administrative Contractors (MACs) contractor price these procedures. **The RUC recommends contractor pricing CPT codes 53451, 53452, 53453, and 53454**.

New Technology
CPT codes 53451, 53452, 53453, and 53454 will be placed on the New Technology list and be re-reviewed by the RUC in two years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Urinary System Urethra Repair				
●53451	N1	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance (Do not report 53451 in conjunction with 52000, 53452, 53453, 53454, 76000)	010	Contractor Price
●53452	N2	unilateral insertion, including cystourethroscopy and imaging guidance	010	Contractor Price

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		(Do not report 53452 in conjunction with 52000, 53451, 53453, 53454, 76000)		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

●53453	N3	removal, each balloon (Do not report 53453 in conjunction with 52000, 53451, 53452, 53454)	000	Contractor Price
●53454	N4	percutaneous adjustment of balloon(s) fluid volume (Do not report 53454 in conjunction with 53451, 53452, 53453) (Report 53454 only once per patient encounter)	000	Contractor Price
Category III Codes				
~~0548T~~	-	~~Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy~~	~~YYY~~	N/A
~~0549T~~	-	~~unilateral placement, including cystoscopy and fluoroscopy~~	~~YYY~~	N/A
~~0550T~~	-	~~removal, each balloon~~	~~YYY~~	N/A
~~0551T~~	-	~~adjustment of balloon(s) fluid volume~~ ~~(Do not report 0551T in conjunction with 0548T, 0549T, 0550T)~~ (0548T, 0549T, 0550T, 0551T have been deleted) (To report bilateral insertion, unilateral insertion, removal, or fluid adjustment of a periurethral adjustable balloon continence device, see 53451, 53452, 53453, 53454)	~~YYY~~	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

American Urological Association

BOARD OF DIRECTORS

Officers

Scott K. Swanson, MD
President

Raju Thomas, MD
President-elect

John H. Lynch, MD
Immediate Past President

John D. Denstedt, MD
Secretary

David F. Green, MD
Treasurer

Thomas F. Stringer, MD
Treasurer-elect

Section Representatives

Kurt A. McCammon, MD
Mid-Atlantic

E. Ann Gormley, MD
New England

Reza Ghavamian, MD
New York

James C. Ulchaker, MD
North Central

Barry A. Kogan, MD
Northeastern

Anthony Y. Smith, MD
South Central

Martin K. Dineen, MD
Southeastern

Eric J. Zeidman, MD
Western

December 10, 2020

Peter Smith, MD
Chair, Relative Value Scale Update Committee (RUC)
American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

RE: Tab 11: Periurethral Balloon Continence Device Procedures

Dear Dr. Smith,

The American Urological Association (AUA) would like to make recommendations based on our survey for the Periurethral Balloon Continence Device Procedures (CPT codes 53451, 53452 53453, and 53454) for the upcoming January RUC meeting. These codes were converted from Category III to Category I codes at the October CPT meeting triggering this survey. Based on this action, these codes will appear in the 2022 CPT book as Category I services.

The survey process has been a challenging one because these are currently Category III codes with low utilization. The manufacturer, Uromedica, estimated that less than 500 of these procedures will be performed in 2021. The RUC's research subcommittee granted the AUA permission to do a targeted survey using the manufacturer's list of 65 physicians who have been trained to do this procedure, of which only 38 physicians have actually performed these procedures. In our survey, we also included a list of 343 subset of AUA members who specialized in these type of procedures.

Despite targeting the survey, we only have received four completed surveys and we needed a total of 30 responses for it to be a valid survey. Therefore, we recommend that CMS have their Medicare Administrative Contractors (MAC) carrier price these procedures.

Headquarters

Michael T. Sheppard, CPA, CAE
Chief Executive Officer

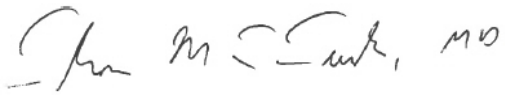
1000 Corporate Boulevard
Linthicum, MD 21090

U.S. Toll Free: 1-866-RING-AUA (1-866-746-4282)
Phone: 410-689-3700
Fax: 410-689-3800
Email: AUA@AUAnet.org
Websites: AUAnet.org
UrologyHealth.org
UrologicHistory.museum

American Urological Association

If you need any other information, please contact Keith Hawman, Public Policy Manager at khawman@auanet.org or at 443-810-3472.

Sincerely,



Thomas M.T. Turk, M. D.
RUC AUA Advisor

AMA/Specialty Society RVS Update Committee (RUC) Vendor/Company Attestation Statement

This form needs to be completed by an authorized representative of any Vendor or Company that makes, markets or distributes a product or device utilized in performing the service being surveyed by the AMA/Specialty Society RVS Update Committee (RUC), as part of its CPT® code survey and valuation process, and which has supplied a list of users of such products or devices in connection with the survey and valuation process.

By submitting to the RUC a list of users of the undersigned's product or device as part of the RUC's CPT® code survey and valuation process, I attest that no employee, affiliate, or agent of the undersigned has contacted, and further covenant that they will not contact, any such user in connection with the survey. I hereby represent and warrant that I have the authority to sign this statement on behalf of the undersigned company and that the information herein is true and accurate. I understand that any false or inaccurate information will render the survey invalid, harming both the undersigned and the physicians who use the product or device.

Periurethral Balloon Continence Device Procedures (53451, 53452, 53453, 53454) CPT® Codes

Replacement of four Category III codes with four Category I codes to report periurethral adjustable balloon continence device. CPT® Codes

UROMEDICA, INC. 1840 BERKSHIRE LANE, NORTH, PLYMOUTH, MN 55441

Uromedica, Inc. (Vendor/Company Name)

Timothy C. Cook, Ph.D. PRESIDENT & CEO

Printed Signature and Title

Timothy C. Cook, Ph.D.

Signature

OCTOBER 31ST, 2020

Date Signed

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Intracranial Laser Interstitial Thermal Therapy (LITT) – Tab 12

In October 2020, the CPT Editorial Panel approved the addition of two codes to report laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance (MR) imaging guidance for a single trajectory for 1 simple lesion and multiple trajectories for multiple or complex lesion(s). LITT is a novel procedure that involves multiple steps and movements of the patient through the hospital for different stages of the procedure. The typical facility does not have an interoperative MRI suite (small minority of academic medical centers may), so patient transport is necessary.

61736 ***Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion***
The RUC reviewed the survey results from 48 neurosurgeons and determined that the survey median work RVU of 20.00 appropriately accounts for the physician work required to perform this service. The RUC recommends the physician times as supported by the survey: 113 minutes pre-service time (68 minutes evaluation, 30 minutes positioning, 15 minutes scrub/dress/wait time), 180 minutes intra-service time, and 60 minutes immediate post-service time. Though the median survey post-service time was 40 minutes, the CMS 23-hour stay policy was applied resulting in 60 minutes.

The RUC discussed the CMS 23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy as it relates to the post-service time for the survey codes. CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as 23-hour stay outpatient services. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to include bundle subsequent hospital visits (eg 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intra-service portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure. The RUC noted that the survey codes have 000-day global periods which typically do not allow for an Evaluation and Management (E/M) visit on the same day as the procedure. Per the CMS policy, the intra-service time is reallocated from the same-day E/M code 99232 to the immediate post-service time of the outpatient service (adding 20 minutes of intra-service time from 99232).

The RUC noted that close monitoring during the first 12-24 hours after brain surgery is critical to a successful outcome. One hundred percent of the survey respondents indicated that a visit would be required later the same day of the procedure. The median response for level of visit was 99232. Therefore, the final immediate post-service time recommended is 60 minutes = 33 (post-service time package 9b) + 7 (additional time related to hardware removal and documentation) + 20 (post-operative visit intra-service time).

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC also noted that the pre-service time is appropriate due to the imaging that occurs as part of the pre-service evaluation time. Preoperative MRI volumetric planning is performed just prior to the procedure. Planning for the procedure and coordination with the healthcare delivery team add a significant amount of time to the work typically assigned to pre-service time package 4. In addition, the RUC specifically inquired about the transfer time for the MRI that occurs within the intra-service period. This was described as a high intensity, sterile transport within the confines of a surgical procedure, with care to protect the laser assembly and anchor bolt, with the surgeon engaged the entire time.

To justify a work RVU of 20.00, the RUC compared CPT code 61736 to the two key reference service codes 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU = 15.00, 100 minutes intra-service time and 241 minutes total time) and 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (work RVU = 12.32, 90 minutes intra-service time and 233 minutes total time) and noted that although the codes all require intracranial work, intraoperative imaging and significant postoperative care, the survey code has much greater intra-service and total times. Neither codes 61645 nor 61640 include the significant preoperative evaluation and positioning time required for 61736. The survey code was considered more intense/complex overall by 84% of survey respondents that selected the top key reference code and 100% of respondents who selected the second key reference code. The RUC recognized that the survey was constrained by a dearth of 000-day global codes familiar to neurosurgeons, making comparison using magnitude estimation difficult. Similarly, there are many MPC codes with a 000 global assignment, but none that approach the work required of CPT code 61736.

For additional support, the RUC agreed that 61736 is appropriately bracketed by comparator codes 33891 *Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision* (work RVU = 20.00, 173 minutes intra-service time and 323 minutes total time) and 33977 *Removal of ventricular assist device; extracorporeal, single ventricle* (work RVU = 20.86, 180 minutes intra-service time and 335 minutes total time) and noted that all three codes require significant pre- and post-service work on the day of the procedure and have the same or similar intra-service time and intensity. The RUC concluded that CPT code 61736 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 20.00 for CPT code 61736.**

61737 ***Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)***

The RUC reviewed the survey results from 44 neurosurgeons and determined that the survey median work RVU of 24.00 appropriately accounts for the physician work required to perform this service. The RUC noted that compared to patients undergoing LITT for a single lesion, the complexity of CPT code 61737 and the level of patient instability and risk is greater. At present, the typical number of "multiple" trajectories is two, thus in many aspects the physician work is doubled. After robust discussion, the RUC recommends the physician times as supported by the survey: 144 minutes pre-service time (93 minutes evaluation, 36 minutes positioning, 15 minutes scrub/dress/wait time), 235 minutes intra-service time, and 40 minutes immediate post-service time and 1-99233 office visit. The RUC noted that these codes have 000-day global periods which typically do not allow for an E/M visit on the same day as the procedure.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

However, unlike code 61736, CPT code 61737 typically involves a full 2-midnight admission, as reflected by the survey respondents, which justifies the same-day E/M visit.

To justify a work RVU of 24.00, the RUC compared CPT code 61737 to the top key reference service code 61645 *Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)* (work RVU = 15.00, 100 minutes intra-service time and 241 minutes total time) and noted that although both codes require intracranial work, intraoperative imaging and significant postoperative care, the reference code requires less intra-service and total time and less positioning time. However, the key reference code 61645 was chosen most often (75%) by survey respondents and is the highest valued code on the reference service list. There are many MPC codes with a 000 global assignment, but none that approach the work required of 61737.

For additional support, the RUC concurred that 61737 is appropriately bracketed by comparator codes 93656 *Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation* (work RVU = 19.77, 240 minutes intra-service time and 309 minutes total time), typically performed as an outpatient procedure in a catheterization lab, and 33976 *Insertion of ventricular assist device; extracorporeal, biventricular* (work RVU = 30.75, 240 minutes intra-service time and 455 minutes total time) and noted that all three codes require similar intra-service time. The RUC concluded that CPT code 61737 should be valued at the median work RVU as supported by the survey. **The RUC recommends a work RVU of 24.00 for CPT code 61737.**

Practice Expense
The Practice Expense Subcommittee accepted the request of the specialties for standard 90-day global preclinical staff times. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology
CPT codes 61736 and 61737 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Nervous System** **Skull, Meninges, and Brain** **Stereotaxis**				
●61736	O1	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion (Do not report 61736, in conjunction with 20660, 61737, 61781, 70551, 70552, 70553, 70557, 70558, 70559, 77021, 77022)	000	20.00
●61737	O2	multiple trajectories for multiple or complex lesion(s) (Do not report 61737 in conjunction with 20660, 61736, 61781, 70551, 70552, 70553, 70557, 70558, 70559, 77021, 77022)	000	24.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61736 Tracking Number O1 Original Specialty Recommended RVU: **20.00**
Presented Recommended RVU: **20.00**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **20.00**

CPT Descriptor: Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion
(Do not report 61736, in conjunction with 20660, 61737, 61781, 70551, 70552, 70553, 70557, 70558, 70559, 77021, 77022)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male with a 10-year history of seizures due to an intracranial tumor that was identified on magnetic resonance imaging (MRI) has failed to respond to medication adjustments to control his weekly seizures. An image-guided stereotactic interstitial laser ablation procedure is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 63%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 60% , Overnight stay-more than 24 hours 40%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Description of Pre-Service Work: Preoperative lab work-up and imaging are reviewed with particular attention to prior CT, MR, and PET scans and noninvasive and invasive EEG results, as appropriate for pre-procedure planning of an optimal trajectory to the targeted lesion. The surgeon reviews the case with the multiple specialists caring for the patient, as needed, to assist with determination of the area to be targeted. Peri-operative medications are ordered. The surgical procedure, risks, and expected outcome are reviewed with the patient and family, and informed consent is obtained. Verification is made that all necessary surgical instruments, supplies, and specialized devices are available in the operative suite and MR suite. The length and type of anesthesia are reviewed with the anesthesiologist and MR suite staff, including expected changes to positioning and the need to transport the patient to and from the MR suite and operating room. The need for radiation protection of all staff during portions of the procedure is reviewed with the procedure team. The patient is positioned in the MR suite to allow for pre-procedure volumetric planning with attention to creating a trajectory for the laser fiber. After induction of general anesthesia, the patient's head is fixed appropriately, such as with an MR-compatible stereotactic head frame, stereotactic robot, or other frameless navigation systems. The patient is then registered into the chosen targeting system by the method appropriate to the system. This may include attaching a fiducial localizer to the frame base (for a stereotactic frame) and conducting further volumetric MRI or CT scans. The patient is transported from the MR suite to the operating room The patient is positioned in a manner that allows for placing the laser bolt and laser and then affixed to the operating table Frameless registration to the stereotactic robot or neuronavigation system is performed as required. Further stereotactic planning is then performed using the images acquired on the day of surgery. The preoperative and same-day imaging sets are loaded in the planning system and merged. Registration is checked for accuracy. The planned trajectories are verified to ensure that they pass through the appropriate structures to be targeted in a manner that allows the laser energy to lesion the target without spreading to brain areas to be preserved while avoiding cortical and sulcal vasculature and the cerebral ventricles. The chosen targeting system is then used to mark the planned entry site. Once the entry site is determined, the area is minimally clipped and widely prepped. The surgeon scrubs and gowns and conducts a procedural time out.

Description of Intra-Service Work: A sterile stereotactic frame arc is then set to appropriate frame coordinates as needed and is mounted over the sterile draped base ring. Alternately, a sterile frameless navigation arm or robotic instrument

holder is attached to the head holder or the previously draped stereotactic robot, respectively, as appropriate. The scalp over the entry site is injected with local anesthetic; a 2 cm incision is made and the soft tissue is cleared from the skull using monopolar cautery. A drill guide tube is lowered into the incision and braced against the bone. The thickness of the skull along the planned trajectory is measured on the navigation plan and the twist drill depth set to the corresponding length. A twist drill hole is then performed with a twist drill of appropriate diameter for the size of the laser bolt. The guide is replaced with a reducing cannula, and the dura and pia are opened carefully using a long monopolar cautery that has been measured to the appropriate depth. The distance to the target is then obtained from the robot, navigation system, or frame, and a thin stylet is first measured to this distance and then inserted to verify that the pia and dura have been opened and to create a path for the laser. The threaded laser bolt is then screwed into the skull through the chosen targeting device using the correct number of rotations to ensure that it is securely seated. The stereotactic alignment rod is then measured to the target distance and inserted through the anchor bolt and into the brain. Fluoroscopic imaging is used as appropriate to verify the accuracy of the trajectory. The distance to the target from the top of the bolt is calculated. After removing the alignment rod from the anchor bolt, the laser apparatus components are marked at the distance-to-target. These may be slowly and carefully inserted through the anchor bolt either at this point or after transport to MRI, as appropriate.

The drapes are removed, and the patient is carefully detached from the table, making sure to protect the anchor bolt, and laser (if inserted) from both movement and for sterility. The patient is then carefully transported to the MRI suite and placed supine within the magnet with the head turned to situate the treatment side up, to protect the laser assembly and anchor bolt. If necessary, any sterile covering of the anchor bolt is removed, and the laser probe apparatus is then measured to the appropriate length and delivered to the intended target in the brain. A volumetric image is acquired to confirm the placement of the laser tip at the intended target. The image is co-registered with the preoperative imaging in the laser ablation software workstation in the MRI control room. The software is used to identify the intended ablation target boundary(s), and the location of the probe on imaging is verified. Temperature reference points and safety limits are marked on the laser ablation software. Continuous MRI thermometry is initiated and streamed to the workstation, where thermal maps are superimposed over static images of the target area. Laser energy is delivered to the target while continuously monitoring subsequent thermal dose damage contour lines created by program software as tissue is heated to the required temperatures. The laser position is then altered as necessary, and laser energy is delivered to the target while continuously monitoring subsequent thermal dose damage contour lines created by program software as tissue is heated to the required temperatures. This process is repeated as many times as is necessary to create the entire lesion.

Once the intended lesion is created, a final MRI scan is conducted. These images are transferred to the laser workstation and merged with the previous imaging sets. The lesion is compared to the plan and the lesion as estimated by the laser software. Once the lesion is declared complete. The patient is withdrawn from the MRI, the laser applicators and anchor bolts are completely removed and incisions are closed.

Description of Post-Service Work:
End of procedure through discharge from recovery: The stereotactic frame is removed and sterile dressings are applied. The patient is monitored during the reversal of anesthesia. Assistance is provided in the transfer of the patient from the operating table to the gurney. Transport of the patient from the MR room to the recovery room is monitored. Postoperative recovery care is discussed with anesthesia and nursing staff. The procedure and outcome are discussed with the family in the waiting area. A brief operative note is written. An operative report is dictated that includes the documentation of imaging, stereotactic calculations, and operative imaging. When awake, the patient's neurological status is assessed. A postoperative progress note is written in the recovery room. The patient is discharged from the recovery room to the ICU or surgical floor bed, as appropriate. Orders for medication, labs, imaging, and monitoring are written and discussed with the nursing staff. Clinical variables -including hemodynamic, neurologic, and cognitive status, shivering, and postoperative nausea and vomiting- are especially relevant after brain surgery and need to be strictly monitored, often every hour.

Work later on the same day: Interval chart notes with an emphasis on neurological monitoring are reviewed. The patient's neurological status is assessed by the surgeon, including the level of consciousness, Glasgow Coma Scale, motor assessment, sensory assessment, and assessment for neurologic complications, including focal deficits from the lesion, cerebral edema, intracranial hemorrhage, seizures, stroke, pneumocephalus, and cerebrospinal fluid leaks. The patient’s case is discussed as needed with the multidisciplinary team caring for the patient. Orders for consultations from these specialists are written as appropriate. The patient's pain score is assessed. Advanced imaging is ordered as appropriate. Patient and family questions are answered. Orders are written and discussed with the nursing staff. Progress notes are recorded.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	John Ratliff, MD; Clemens Schirmer, MD; Joshua Rosenow, MD					
Specialty Society(ies):	AANS, CNS					
CPT Code:	61736					
Sample Size:	515	**Resp N:**	48			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**6.00**	10.00	25.00	
Survey RVW:	8.00	17.78	**20.00**	30.00	64.00	
Pre-Service Evaluation Time:			**68.00**			
Pre-Service Positioning Time:			**30.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	45.00	128.00	**180.00**	201.00	360.00	
Immediate Post Service-Time:	**40.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	61736	**Recommended Physician Work RVU: 20.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**68.00**	**40.00**	**28.00**
Pre-Service Positioning Time:		**30.00**	**3.00**	**27.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**180.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**60.00**	**33.00**	**27.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61645	000	15.00	**RUC Time**

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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61640	000	12.32	**RUC Time**

CPT Descriptor Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 54.1 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 14.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 61736	Top Key Reference CPT Code: 61645	2nd Key Reference CPT Code: **61640**
Median Pre-Service Time	113.00	58.00	58.00
Median Intra-Service Time	180.00	100.00	90.00
Median Immediate Post-service Time	60.00	83.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	55.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**353.00**	**241.00**	**233.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	4%	0%	12%	42%	42%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	19%	81%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	42%	54%
Physical effort required	4%	23%	73%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	12%	31%	58%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	43%	57%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	14%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	29%	29%	43%
Physical effort required	29%	14%	57%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	14%	43%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Recommendation

We recommend the survey median wRVU of 20.00

Pre-time

Package 4 is selected with the following modifications:

Evaluation time: Package time of 40 minutes plus an additional 28 minutes (total = 68 minutes). This operation includes atypical additional coordination with multiple healthcare providers, not only for pre-operative planning, but also regarding post-operative care. Preoperative MRI volumetric planning is performed just prior to the procedure. Planning for the procedure and coordination with the healthcare delivery team add a significant amount of time to the work typically assigned to Package 4 – as described in the preoperative work description. In support of 68 minutes (survey median time), please see similar codes 61540 (*Craniotomy with elevation of bone flap; for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery*) and code 61566 (*Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy*) that include 75 minutes of preoperative evaluation time. These codes similarly include extensive evaluation and planning for the surgical approach in addition to coordination with other health care providers. In addition, the recommended evaluation time of 68 minutes is the same as the evaluation time for code 33889 (*Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral*) which involves similar preoperative evaluation and planning to review MR, CT and CT with 3D reconstructions, along with many other imaging studies.

Positioning time: Package time of 3 minutes plus an additional 27 minutes (total = 30 minutes). Depending on the target area, the patient can be placed supine sitting, lateral, or prone. There is no typical position and dominant is split between supine sitting and prone, but can vary every year based on patient presentation. A significant amount of time is required related to positioning the patient relative to the imaging and laser equipment, along with application of devices to affix the head to the equipment and to the operating table. This additional work is described in more details in the preoperative work description. In support of 30 minutes (survey median time), please see similar codes 61697 (*Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation*) and code 61700 (*Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation*) that include 30 minutes of preoperative positioning for "stabilization of the patient's head in a pin fixation device." In addition, the recommended positioning time of 30 minutes compares well with many other codes that have 25-35 minutes, such as laparoscopy procedures and procedures that include extensive equipment in the surgical field or require intraoperative repositioning.

Scrub, dress, wait time: Subtract 5 minutes (total time = 15 minutes) to be consistent with survey median.

Immediate Post-time

Package 9b is selected with the following modifications: (1) add 7 minutes for additional work related to removal of hardware and additional time for documentation of the procedure; and (2) add 20 minutes per CMS 23-hour stay policy regarding visit(s) on the day of a procedure that is assigned facility outpatient status. One hundred percent of the respondents correctly indicated that a visit would be required later on the same day of the procedure. The median response for level of visit was 99232. Close monitoring during the first 12-24 hours after brain surgery are critical to a successful outcome. The assessment later on the day of the procedure, along with other work as described in the DOW would typically require at least 20 minutes (the intra-service time for 99232). The final total time recommended is 60 minutes = 33 (package time) +7 (add'l time related to hardware removal and documentation) +20 (visit later same day).

Key Reference Code Comparison

KRS 1: Code 61645 requires less total time, intra-time and positioning time. Both codes require intracranial work, intraoperative imaging and significant postoperative care. We note that our survey was constrained by a dearth of 0-day global codes familiar to neurosurgeons. Code 61645 was chosen most often (54%) and is the highest valued code on the reference service list.

KRS 2: Code 61640 requires less total time, intra-time and positioning time. Similar to the statement above, our survey was constrained by a dearth of 0-day global codes familiar to neurosurgeons, making comparison using magnitude estimation difficult.

Neither 61645 or 61640 include the significant preoperative evaluation and positioning required for 61736. All three codes require significant postop work on the day of the procedure.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	IMM POST	99233
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	15.00	0.121	241	40	3	15	100	83	
61736	Laser interstitial thermal therapy (LITT)	20.00	0.091	353	68	30	15	180	60	

	of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion									
61640	Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel	12.32	0.095	233	40	3	15	90	30	1

MPC Code Comparison

There are many MPC codes with a 000 global assignment, but none that approach the work required of 61736. This makes finding appropriate MPC codes with similar total work difficult. MPC code 37244 (with the highest wRVU) is an emergent procedure performed in a cath lab to embolize or occlude vessel hemorrhage or lymphatic extravasation. Code 37244 requires significantly less total time, intra-time and pre/post time. Both 37244 and 61736 require intraoperative imaging. The higher IWPUT for 37244 when compared with 61736 may be reflective of the emergent nature of the procedure.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	IMM POST
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	13.75	0.135	166	23	3	5	90	45
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	20.00	0.091	353	68	30	15	180	60

Other Code Comparison

Codes 33891 and 33977 bracket the recommendation of work and time for 61736. All three codes require significant pre- and post-work on the day of the procedure and have the same or similar intraoperative time and intensity.

CPT	DESCRIPTOR	Glob	RVW	IWPUT	TOTAL TIME	PRE	INTRA	IMM POST
33891	Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	000	20.00	0.098	323	110	173	40
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	000	20.00	0.091	353	113	180	60
33977	Removal of ventricular assist device; extracorporeal, single ventricle	XXX	20.86	0.098	335	95	180	60

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1465
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 estimate based on published literature and manufacturer sales records.

Specialty neurosurgery Frequency 1465 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 372
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on specialty estimate: 5% of 2019 utilization for 64999 (5% x 7432)

Specialty neurosurgery Frequency 372 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63194

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61737 Tracking Number O2 Original Specialty Recommended RVU: **24.00**
Presented Recommended RVU: **24.00**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **24.00**

CPT Descriptor: Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)
(Do not report 61737 in conjunction with 20660, 61736, 61781, 70551, 70552, 70553, 70557, 70558, 70559, 77021, 77022)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old male with a 15-year history of seizures due to a large complex hypothalamic hamartoma identified on magnetic resonance imaging (MRI) has failed to respond to medication adjustments to control his weekly seizures. An image-guided stereotactic interstitial laser ablation procedure including multiple laser trajectories is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 25% , Overnight stay-more than 24 hours 75%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Description of Pre-Service Work: Preoperative lab work-up and imaging are reviewed with particular attention to prior CT, MR, and PET scans and noninvasive and invasive EEG results, as appropriate for pre-procedure planning of an optimal multiple trajectories to the targeted lesion. The surgeon reviews the case with the multiple specialists caring for the patient, as needed, to assist with determination of the areas to be targeted. Peri-operative medications are ordered. The surgical procedure, risks, and expected outcome are reviewed with the patient and family, and informed consent is obtained. Verification is made that all necessary surgical instruments, supplies, and specialized devices are available in the operative suite and MR suite. The length and type of anesthesia are reviewed with the anesthesiologist and MR suite staff, including expected changes to positioning and the need to transport the patient to and from the MR suite and operating room. The need for radiation protection of all staff during portions of the procedure is reviewed with the procedure team. The patient is positioned in the MR suite to allow for pre-procedure volumetric planning with attention to creating multiple trajectories for multiple laser fibers. After induction of general anesthesia, the patient's head is fixed appropriately, such as with an MR-compatible stereotactic head frame, stereotactic robot, or other frameless navigation systems. The patient is then registered into the chosen targeting system by the method appropriate to the system. This may include attaching a fiducial localizer to the frame base (for a stereotactic frame) and conducting further volumetric MRI or CT scans. The patient is transported from the MR suite to the operating room The patient is positioned in a manner that allows for placing the laser bolt and laser and then affixed to the operating table Frameless registration to the stereotactic robot or neuronavigation system is performed as required. Further stereotactic planning is then performed using the images acquired on the day of surgery. The preoperative and same-day imaging sets are loaded in the planning system and merged. Registration is checked for accuracy. The planned trajectories are verified to ensure that they pass through the appropriate structures to be targeted in a manner that allows the laser energy to lesion the target without spreading to brain areas to be preserved while avoiding cortical and sulcal vasculature and the cerebral ventricles. The chosen targeting system is then used to mark the planned entry sites. Once the entry sites are determined, the areas are minimally clipped and widely prepped. The surgeon scrubs and gowns and conducts a procedural time out.

Description of Intra-Service Work: A sterile stereotactic frame arc is set to appropriate frame coordinates as needed and is mounted over the draped base ring. Alternately a sterile frameless navigation arm or robotic instrument holder is attached to the head holder or the previously draped stereotactic robot, respectively, as appropriate. The scalp over the entry site is injected with local anesthetic; a 2 cm incision is made. The soft tissue is cleared from the skull using monopolar cautery and a drill guide tube is lowered into the incision and braced against the bone. The thickness of the skull along the planned trajectory is measured on the navigation plan and the twist drill depth set to the corresponding length. A twist drill hole is then performed with a twist drill of appropriate diameter for the size of the laser bolt. The guide is replaced with a reducing cannula, and the dura and pia are opened carefully using a long monopolar cautery that has been measured to the appropriate depth. The distance to the target is then obtained from the robot, navigation system, or frame, and a thin stylet is first measured to this distance and then inserted to verify that the pia and dura have been opened and to create a path for the laser. The threaded laser bolt is then screwed into the skull through the chosen targeting device using the correct number of rotations to ensure that it is securely seated. The stereotactic alignment rod is then measured to the target distance and inserted through the anchor bolt and into the brain. Fluoroscopic imagine is used as appropriate to verify the accuracy of the trajectory. The distance to the target from the top of the bolt is calculated. After removing the alignment rod from the anchor bolt, the laser apparatus components are marked at the distance-to-target. These may be slowly and carefully inserted through the anchor bolt either at this point or after transport to the MR suite, as appropriate.

Moving on, the navigation system is then aligned to the next trajectory and to mark the next entry point. Local anesthetic is infiltrated in this region, another incision is made, and the next anchor bolt and laser are inserted in similar fashion to the first. This process is then repeated for each subsequent required laser trajectory.

The drapes are removed, and the patient is carefully detached from the table, making sure to protect the anchor bolt, and laser (if inserted) from both movement and for sterility. After all anchor bolts have been placed, the patient is then carefully transported to the MRI suite and placed supine within the magnet with the head turned to situate the treatment side up, to protect the laser assemblies and anchor bolts. If necessary, any sterile coverings of the anchor bolts are removed, and each laser probe apparatus is then measured to the appropriate length and delivered to the intended target in the brain through the corresponding anchor bolt. A volumetric image is acquired to confirm the placement of each of the laser tips at the intended target. The image is co-registered with the preoperative imaging in the laser ablation software workstation in the MRI control room. The software is used to identify the intended ablation target boundary(ies), and the location of each probe on imaging is verified. The first laser trajectory is then selected and the imaging is aligned to this trajectory. Temperature reference points and safety limits are marked on the laser ablation software. Continuous MRI thermometry is initiated and streamed to the workstation, where thermal maps are superimposed over static images of the target area. Laser energy is delivered to the target while continuously monitoring subsequent thermal dose damage contour lines created by program software as tissue is heated to the required temperatures. The laser position is then altered as necessary, and laser energy is delivered to the target while continuously monitoring subsequent thermal dose damage contour lines created by program software as tissue is heated to the required temperatures. This process is repeated as many times as is necessary to create the entire lesion.

The imaging is then aligned to the next laser trajectory. Temperature reference points and safety limits are marked on the laser ablation software. Continuous MRI thermometry is initiated and streamed to the workstation, where thermal maps are superimposed over static images of the target area. Laser energy is delivered to the target while continuously monitoring subsequent thermal dose damage contour lines created by program software as tissue is heated to the required temperatures. The laser position is then altered as necessary, and laser energy is delivered to the target while continuously monitoring subsequent thermal dose damage contour lines created by program software as tissue is heated to the required temperatures. This process is repeated as many times as is necessary to create the entire lesion. This process is then repeated for each subsequent laser trajectory.

Once all of the intended lesions are created with the multiple laser trajectories, a final MRI scan is conducted. These images are transferred to the laser workstation and merged with the previous imaging sets. The set of lesions are compared to the plan and the estimate from the laser software. Once the set of lesions is declared complete. The patient is withdrawn from the MRI, the laser applicators and anchor bolts are completely removed and incisions are closed.

Description of Post-Service Work:
End of procedure through discharge from recovery: The stereotactic frame is removed and sterile dressings are applied. The patient is monitored during the reversal of anesthesia. Assistance is provided in the transfer of the patient from the operating table to the gurney. Transport of the patient from the MR room to the recovery room is monitored. Postoperative recovery care is discussed with anesthesia and nursing staff. The procedure and outcome are discussed with the family in the waiting area. A brief operative note is written. An operative report is dictated that includes the documentation of

imaging, stereotactic calculations, and operative imaging. When awake, the patient's neurological status is assessed. A postoperative progress note is written in the recovery room. The patient is discharged from the recovery room to the ICU or surgical floor bed, as appropriate. Orders for medication, labs, imaging, and monitoring are written and discussed with the nursing staff. Clinical variables -including hemodynamic, neurologic, and cognitive status, shivering, and postoperative nausea and vomiting- are especially relevant after brain surgery and need to be strictly monitored, often every hour.

Work later on the same day: Interval chart notes with an emphasis on neurological monitoring are reviewed. The patient's neurological status is assessed by the surgeon, including the level of consciousness, Glasgow Coma Scale, motor assessment, sensory assessment, and assessment for neurologic complications, including focal deficits from the lesion, cerebral edema, intracranial hemorrhage, seizures, stroke, pneumocephalus, and cerebrospinal fluid leaks. The patient’s case is discussed as needed with the multidisciplinary team caring for the patient. Orders for consultations from these specialists are written as appropriate. The patient's pain score is assessed. Advanced imaging is ordered as appropriate. Patient and family questions are answered. Orders are written and discussed with the nursing staff. Progress notes are recorded.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	John Ratliff, MD; Clemens Schirmer, MD; Joshua Rosenow, MD					
Specialty Society(ies):	AANS, CNS					
CPT Code:	61737					
Sample Size:	515	**Resp N:**	44			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**2.00**	5.00	15.00	
Survey RVW:	9.85	18.38	**24.00**	32.75	90.00	
Pre-Service Evaluation Time:			**93.00**			
Pre-Service Positioning Time:			**36.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	90.00	180.00	**235.00**	279.00	480.00	
Immediate Post Service-Time:	**40.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**55.00**	99231x **0.00** 99232x **0.00** 99233x **1.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	61737	**Recommended Physician Work RVU: 24.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**93.00**	**40.00**	**53.00**
Pre-Service Positioning Time:		**36.00**	**3.00**	**33.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**235.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**40.00**	**33.00**	**7.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	55.00	99231x **0.00** 99232x **0.00** 99233x **1.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
61645	000	15.00	**RUC Time**

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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20982	000	7.02	**RUC Time**

CPT Descriptor Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
	000	0.00	**RUC Time**	

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 33 **% of respondents:** 75.0 **%**

Number of respondents who choose 2nd Key Reference Code: 3 **% of respondents:** 6.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 61737	Top Key Reference CPT Code: 61645	2nd Key Reference CPT Code: **20982**
Median Pre-Service Time	144.00	58.00	38.00
Median Intra-Service Time	235.00	100.00	80.00
Median Immediate Post-service Time	40.00	83.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	55.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**474.00**	**241.00**	**148.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	3%	9%	27%	61%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	9%	88%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	6%	24%	70%
Physical effort required	0%	30%	70%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	18%	21%	61%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	0%	100%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	67%	33%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	0%	100%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Recommendation

We recommend the survey median wRVU of 24.00

Pre-time

Package 4 is selected with the following modifications:

Evaluation time: Package time of 40 minutes plus an additional 53 minutes (total = 93 minutes). This operation includes atypical additional coordination with multiple healthcare providers, not only for pre-operative planning, but also regarding post-operative care. Preoperative MRI volumetric planning is performed just prior to the procedure. Planning for the procedure and coordination with the healthcare delivery team add a significant amount of time to the work typically assigned to Package 4 – as described in the preoperative work description. When compared with planning for 61736 (single trajectory for simple lesion), the planning for 61737 (multiple trajectories for multiple or complex lesion[s]) is significantly greater. In support of 93 minutes (survey median time), please see code 33880 (*Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin)* that includes 90 minutes of preoperative evaluation time. This code similarly includes extensive evaluation and planning for the procedure ("*Perform extensive review and measurement of imaging studies (some combination of CT , CT angiogram, CT with 3-D reconstructions, MRI, angiograms) to determine the exact measurements of aorta. Based on measurements, determine all potential components required for repair, plus contingencies and backups"*). In addition, the recommended evaluation time of 93 minutes is slightly less than the 110 minutes of evaluation time for endovascular repair codes 34701, 34703, 34705, 34707, 34710, 34718 that include preoperative planning.

Positioning time: Package time of 3 minutes plus an additional 33 minutes (total = 33 minutes). Depending on the target area(s), the patient can be placed supine sitting, lateral, or prone. There is no typical position and dominant is split between supine sitting and prone, but can vary every year based on patient presentation. A significant amount of time is required related to positioning the patient relative to the imaging and laser equipment, along with application of devices to affix the head to the equipment and to the operating table. This additional work is described in more details in the preoperative work description. In support of 36 minutes (survey median time), please see similar codes 61697 (*Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation*) and code 61700 (*Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation*) that include 30 minutes of preoperative positioning for "stabilization of the patient's head in a pin fixation device." The additional positioning time for 61737 compared with code 61700 and code 61736 relates to the need for additional positioning for more trajectories. In addition, the recommended positioning time of 36 minutes compares well with many other codes that have 30-35 minutes, such as laparoscopy procedures and procedures that include extensive equipment in the surgical field or require intraoperative repositioning.

Scrub, dress, wait time: Subtract 5 minutes (total time = 15 minutes) to be consistent with survey median.

Immediate Post-time

Package 9b is selected with the following modifications: (1) add 7 minutes for additional work related to removal of hardware and additional time for documentation of the procedure

Evaluation and management work later on the day of the procedure.

One hundred percent of the respondents indicated and E/M would be provided later on the same day of the procedure and 75% of the respondents indicated the typical patient will be admitted. The stakeholder societies believe the percentage inpatient admission is likely higher than this survey estimate. Although the E/M work later on the same day is similar to patients undergoing LITT for a single lesion, the complexity of the medical decision making is greater, the time required for the E/M work is greater, and the level of patient instability is greater. The survey median level of E/M visit was 99233.

Key Reference Code Comparison

KRS 1: Code 61645 requires less total time, intra-time and positioning time. Both codes require intracranial work, intraoperative imaging and significant postoperative care. We note that our survey was constrained by a dearth of 0-day global codes familiar to neurosurgeons. Code 61645 was chosen most often (75%) and is the highest valued code on the reference service list.

KRS 2: Code 20982 requires less time in every category. This is not a good reference, but reflects an example of references chosen by 1, 2, or 3 respondents. We note that when this reference was chosen, the wRVU estimate was about three times greater.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	IMM POST	99233
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or	15.00	0.121	241	40	3	15	100	83	

	infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)									
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	24.00	0.077	474	93	36	15	235	40	1
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	7.92	0.070	148	13	15	10	80	30	

MPC Code Comparison

There are many MPC codes with a 000 global assignment, but none that approach the work required of 61737. This makes finding appropriate MPC codes with similar total work difficult. MPC code 37244 (with the highest wRVU) is an emergent procedure performed in a cath lab to embolize or occlude vessel hemorrhage or lymphatic extravasation. Code 37244 requires significantly less total time, intra-time and pre/post time. Both 37244 and 61737 require intraoperative imaging. The higher IWPUT for 37244 when compared with 61737 may be reflective of the emergent nature of the procedure.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	IMM POST	99233
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	13.75	0.135	166	23	3	5	90	45	
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	24.00	0.077	474	93	36	15	235	40	1

Other Code Comparison

Codes 93656 and 33976 bracket the recommendation of work and time for 61737. All three codes require significant intra-time. Code 93656 is typically performed as an outpatient procedure in a cath lab.

CPT	DESCRIPTOR	Glob	RVW	IWPUT	TOTAL TIME	EVAL	POSIT	SDW	INTRA	IMM POST	99233
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation	000	19.77	0.076	309	23	1	5	240	40	
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	000	24.00	0.077	474	93	35	16	235	40	1
33976	Insertion of ventricular assist device; extracorporeal, biventricular	XXX	30.75	0.109	455	60	15	20	240	120	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64999

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 350
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 estimate based on published literature and manufacturer sales records.

Specialty neurosurgery Frequency 350 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 93 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on specialty estimate: 1.25% of 2019 utilization for 64999 (1.25% x 7432)

Specialty neurosurgery Frequency 93 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63194

ISSUE: Intracranial Laser Interstitial Thermal Therapy (LITT)

TAB: 12

							RVW					Total	PRE			INTRA					POST				12 Month Svy Experience				
SOURCE	CPT	Glob	DESC	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	33	32	31	MIN	25th	MED	75th	MAX
REF1	61645	000	Percutaneous arterial transluminal mech	26	0.121	0.062			15.00			241	40	3	15			100			83									
REF2	61640	000	Balloon dilatation of intracranial vasospa	7	0.095	0.053			12.32			233	40	3	15			90			30	1								
current	64999	YYY	Unlisted procedure, nervous system		n/a	n/a			0.00			0																		
SVY	61736	000	Laser interstitial thermal therapy (LIT	48	0.086	0.054	8.00	17.78	20.00	30.00	64.00	373	68	30	15	45	128	180	201	360	40	1			0	2	6	10	25
REC	61736	000	median		0.091	0.057			20.00			353	68	30	15			180			60									
REF1	61645	000	Percutaneous arterial transluminal mech	33	0.121	0.062			15.00			241	40	3	15			100			83									
REF2	20982	000	Ablation therapy for reduction or eradicat	3	0.070	0.047			7.02			148	13	15	10			80			30									
current	64999	YYY	Unlisted procedure, nervous system		n/a	n/a			0.00			0																		
SVY	61737	000	Laser interstitial thermal therapy (LIT	44	0.077	0.051	9.85	18.38	24.00	32.75	90.00	474	93	36	15	90	180	235	279	480	40	1			0	1	2	5	15
REC	61737	000	median		0.077	0.051			24.00			474	93	36	15			235			40	1								

FACILITY DIRECT PE INPUTS **CPT CODE(S):** 61736, 61737

SPECIALTY SOCIETY(IES): AANS, CNS

PRESENTER(S): John Ratliff, MD; Clemens Schirmer, MD; Joshua Rosenow, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 01/2021

CPT Code	Long Descriptor	Global Period
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	000
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
61736	A 45-year-old male with a 10-year history of seizures due to an intracranial tumor that was identified on magnetic resonance imaging (MRI) has failed to respond to medication adjustments to control his weekly seizures. An image-guided stereotactic interstitial laser ablation procedure is performed.
61737	A 25-year-old male with a 15-year history of seizures due to a large complex hypothalamic hamartoma identified on magnetic resonance imaging (MRI) has failed to respond to medication adjustments to control his weekly seizures. An image-guided stereotactic interstitial laser ablation procedure including multiple laser trajectories is performed.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A joint RVS Committee representing the societies utilized a consensus panel to develop recommended inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Two reference codes have been provided. One is a 000 global code to support the recommended time for these 000 global codes. The second reference code with a 090 global assignment represents a similar procedure requiring similar pre-service clinical staff work.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   The standard for 0-day global codes is 0 minutes clinical staff time. Codes 61736 and 61737 services are exclusively performed in the facility setting and require office clinical staff time typical of 90-day global procedures performed in the facility setting. The LITT procedures are performed under general anesthesia and require specialized supplies and equipment and pre-operative coordination between

multiple specialists and both the OR and MR suites. The main reason these codes were assigned a 000 day global period instead of 90 days is to accommodate the postoperative multispecialty care that is shared (eg, neurosurgeon, neurologist).
The clinical staff PE inputs were derived from comparison to 33361 (TAVR) which represents a procedure performed by a cardiologist and cardiovascular surgeon requiring additional scheduling and coordination of services between cardiology, cardiovascular surgery, radiology, perfusionist and a specialized anesthesiologist. This same coordination with multiple specialists applies to the LITT procedures. In addition, the TAVR procedure requires a hybrid OR room requiring special equipment for the catheter-based, surgical, and imaging aspects of the procedure and the cardiopulmonary bypass equipment all of which must be ordered and coordinated by each physician's clinical staff. Similarly, the LITT procedures require specialized equipment and supplies in both the OR and the MR suites as the patient will have parts of the procedure performed in each setting (please see the work DOW).
The recommended clinical staff PE inputs can also be compared to 61720 as this procedure requires the same coordination of a team and separate rooms (MR and OR suites) in preparation for the procedure.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

n/a

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

n/a

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

CA001 (complete pre-service diagnostic and referral forms): The clinical staff will complete pre-service diagnostic and referral forms, including scheduling preoperative clearance and securing insurance prior authorization.

CA002 (coordinate pre-surgery services): Clinical staff coordination communications between the multidisciplinary team caring for this patient in preparation for the procedure. Preoperative labs and imaging and historical imaging are collected for preoperative planning by the neurosurgeon.

CA003 (schedule space and equipment in facility): In addition to coordinating all of the specialists involved, the specialized supplies, devices, and equipment in both the OR and MR are coordinated and scheduled.

CA004 (provide education/obtain consent): The patient and family will be educated about the procedure including the details of affixing the head frame, intraoperative transport and MR positioning, imaging and treatment.

CA005 (complete pre-procedure phone calls and prescriptions): The patient and family are reminded of the scheduled procedure, given last minute instructions for prep and reporting for the procedure and confirmation of any required adjustments to medications.

   b. Service period (includes pre, intra and post):

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

n/a

c. Post-service period:

n/a

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

n/a

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

n/a

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

n/a

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

n/a

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

n/a

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

n/a

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

n/a

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

n/a

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**REFERENCE CODE**		**RECOMM**
2						**33361**		**61720**		**61**
3		***RUC Collaboration Website***				Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach		Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus		Laser in thermal (LITT) c intracrania burr hol magnetic imaging when pe single traje simple
4	**Clinical Activity Code**	**Meeting Date: 01/2021** **Revision Date (if applicable):** **Tab: 12** **Specialty: AANS, CNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**N/A**	**000**	**N/A**	**090**	**N/A**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 22.20**	**$ -**	**$ 69.35**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**144.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**12.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**72.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 22.20**	**$ -**	**$ 53.28**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		5		5	
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		20		20	
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		8		8	
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37		20		20	
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		7		7	
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**	**12**	**n/a**
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**72.0**	**0.0**
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**REFERENCE CODE**		**RECOMM**
2						**33361**		**61720**		**61**
3		***RUC Collaboration Website***				Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach		Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus		Laser in thermal (LITT) c intracrania burr hol magnetic imaging when pe single traje simple
4	**Clinical Activity Code**	**Meeting Date: 01/2021 Revision Date (if applicable): Tab: 12 Specialty: AANS, CNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**N/A**	**000**	**N/A**	**090**	**N/A**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 22.20**	**$ -**	**$ 69.35**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**144.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**12.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**72.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ 15.45**	**$ -**
102	SA048	pack, minimum multi-specialty visit	4.0507	pack					2	
103	SA054	pack, post-op incision care (suture)	4.6918	pack					1	
104	SG017	bandage, Kling, non-sterile 2in	1.3282	item					2	
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ 0.62**	**$ -**
112	EF023	table, exam	3887.8377		0.008648083				72	
119										

	A	B	L	M	N
1	**RUC Practice Expense Spreadsheet**		**MENDED**	**RECOMMENDED**	
2			**736**	**61737**	
3		***RUC Collaboration Website***	terstitial	Laser interstitial	
4	**Clinical Activity Code**	**Meeting Date: 01/2021** **Revision Date (if applicable):** **Tab: 12** **Specialty: AANS, CNS**	therapy f lesion, , including e(s), with esonance guidance, rformed; ctory for 1 lesion	thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**000**	**N/A**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 22.20**	**$ -**	**$ 22.20**
8		**TOTAL CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 22.20**	**$ -**	**$ 22.20**
13		**PRE-SERVICE PERIOD**			
14		**Start: Following visit when decision for surgery/procedure made**			
15	CA001	Complete pre-service diagnostic and referral forms	5		5
16	CA002	Coordinate pre-surgery services (including test results)	20		20
17	CA003	Schedule space and equipment in facility	8		8
18	CA004	Provide pre-service education/obtain consent	20		20
19	CA005	Complete pre-procedure phone calls and prescription	7		7
29		**End: When patient enters office/facility for surgery/procedure**			
30		**SERVICE PERIOD**			
31		**Start: When patient enters office/facility for surgery/procedure:**			
74	CA036	Discharge day management		**n/a**	
81		**End: Patient leaves office/facility**			
82		**POST-SERVICE PERIOD**			
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**
99		**End: with last office visit before end of global period**			

	A	B	L	M	N
1	**RUC Practice Expense Spreadsheet**		**MENDED**	**RECOMMENDED**	
2			**736**	**61737**	
3		***RUC Collaboration Website***	terstitial	Laser interstitial	
4	**Clinical Activity Code**	**Meeting Date: 01/2021** **Revision Date (if applicable):** **Tab: 12** **Specialty: AANS, CNS**	therapy f lesion, , including e(s), with esonance guidance, rformed; ctory for 1 lesion	thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**000**	**N/A**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 22.20**	**$ -**	**$ 22.20**
8		**TOTAL CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**			
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**
102	SA048	pack, minimum multi-specialty visit			
103	SA054	pack, post-op incision care (suture)			
104	SG017	bandage, Kling, non-sterile 2in			
110	**Equipment Code**	**EQUIPMENT**			
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**
112	EF023	table, exam			
119					

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Hypoglossal Nerve Stimulator Services – Tab 13

In October 2020, the CPT Editorial Panel replaced three CPT Category III codes with three new CPT Category I codes to report open implantation, revision or replacement, and removal of hypoglossal nerve stimulator array. In addition, the CPT Editorial Panel made editorial revisions to codes 64568, 64569, 64570, 64575, 64580, and 64581.

64582 ***Open implantation of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array***
The RUC reviewed the survey results from 89 otolaryngologists and determined that the survey median work RVU of 16.00 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 35 minutes of pre-service evaluation time, 20 minutes of pre-service positioning time, 14 minutes of pre-service scrub/dress/wait time, 140 minutes of intra-service time, 20 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213). The RUC agreed that the recommended 20 minutes of positioning time, an increase of 17 minutes from pre-time package 4, is consistent with the survey median time and necessary for this procedure. Specifically, the chest area must be taped down to access the neck and utilize sleds and belts to secure them. There are two specific surgical sites and patients typically have very large/obese (BMI > 30) body habitus. Positioning requires the physician to access and position the patient in an ergonomic fashion and requires extended neck and chest access throughout the procedure. Additionally, the RUC discussed the relationship with drug induced sleep endoscopy (DISE) services and if there is an overlap with work. The specialty addressed and the RUC agreed that DISE *does* need to be performed to determine candidacy for hypoglossal nerve stimulator services (HGN). However, if the physician performs both services, these elective procedures are often separated by months, given the difficulty of scheduling surgeries at sleep medicine practices, and are not done closely together.

In addition, the RUC thoroughly discussed CPT code 64568 *Incision for implantation of cranial nerve (eg,* ***vagus nerve****) neurostimulator electrode array and pulse generator* (work RVU = 9.00, intra-service time of 90 minutes and total time of 275 minutes) which was reported with deleted Category III codes 0466T-0468T and agreed that the use of this vagus nerve code only represents part of the work involved in hypoglossal nerve stimulator services and does not address the distal inspiratory sensor, which is for a completely different site and incision as well as a completely different disease process and patient population. The physician work for hypoglossal nerve stimulator services is different than vagus nerve work. Identifying and placing a nerve stimulator on the trunk of the vagus nerve is different than identifying and placing a nerve stimulator on the distal and wispy branches of the hypoglossal nerve. The physician must find the specific branch that protrudes the tongue and implant it. Additionally, the physician is putting other cranial nerve branches at risk where they dissect to find the hypoglossal nerve. Hypoglossal nerve services are very different than the vagal nerve service in terms of patient population work intensity and risk. The RUC agreed with the specialty that there is evidence for increasing times and intensity for the additional work involved in the hypoglossal nerve stimulator family.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC compared the survey code to the second key reference code 64911 *Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve* (work RVU = 14.00, intra-service time of 110 minutes and total time of 292 minutes) and noted that although both services involve similar total time, the survey code involves 30 minutes more of intra-service time and more total time, supporting a higher value of 16.00. Most survey respondents that selected the second key reference code 64911, also noted that the survey code was more intense/complex (71%), further warranting a work value of 16.00 for the survey code. Additionally, the RUC referenced code 49655 *Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated* (work RVU= 16.84, intra-service time of 150 minutes and total time of 344 minutes) and noted that code 49655 has 10 more minutes of intra-service time and more total time, warranting the higher work value in comparison to the survey code. **The RUC recommends a work RVU of 16.00 for CPT code 64582.**

64583 ***Revision or replacement of hypoglossal nerve neruostimulator array and distal respiratory sensor electrode or electrode array, including connection to an existing pulse generator***
The RUC reviewed the survey results from 67 otolaryngologists and determined that the survey median work RVU of 16.50 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 20 minutes of pre-service positioning time, 14 minutes of pre-service scrub/dress/wait time, 150 minutes of intra-service time, 20 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

The RUC compared the survey code to code 49655 *Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated* (work RVU = 16.84, intra-service time of 150 minutes and total time of 344 minutes) and noted that both services have identical intra-service times; however, reference code 49655 has more total time, warranting the higher work value than the recommended work value of 16.50 for the survey code. Additionally, the RUC compared the survey code to code 15736 *Muscle, myocutaneous, or fasciocutaneous flap; upper extremity* (work RVU= 17.04, intra-service time of 150 minutes and total time of 396 minutes) and noted that both codes have identical intra-service time, however reference code 15736 has a higher value because this service has more total time, supporting the recommended work value of 16.50 for the survey code. **The RUC recommends a work RVU of 16.50 for CPT code 64583.**

64584 ***Removal of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array***
The RUC reviewed the survey results from 64 otolaryngologists and determined that the survey median work RVU of 14.00 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 40 minutes of pre-service evaluation time, 15 minutes of pre-service positioning time, 15 minutes of pre-service scrub/dress/wait time, 120 minutes of intra-service time, 20 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

The RUC compared the survey code to code 58674 *Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency* (work RVU= 14.08, intra-service time of 120 minutes and total time of 266 minutes) and agreed that both codes involve identical intra-service time and similar total time, warranting the recommended work value of 14.00 compared to 14.08 for code 58674. Additionally, the RUC compared the survey code with MPC code 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56, intra-service time of 120 minutes and total time of 279 minutes) and noted that both codes have identical intra-service times and very similar total times. However, MPC code 58674 is

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

slightly more intense and has 0.56 more work RVUs than the survey code, further supporting the work value of 14.00 for the survey code. **The RUC recommends a work RVU of 14.00 for CPT code 64584.**

Practice Expense
The Practice Expense Subcommittee approved the standard 090-day global period direct practice expense inputs for CPT codes 64582, 64583 and 64584. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Nervous System** **Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System** **Neurostimulators (Peripheral Nerve)**				
(e)64568	-	~~Incision(s) for~~ Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator (Do not report 64568 in conjunction with 61885, 61886, 64570) ~~(For insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator, use 0466T)~~	090	9.00 (No Change) (2021 Work RVU = 9.00)
(e)64569	-	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator (Do not report 64569 in conjunction with 64570 or 61888) (For replacement of pulse generator, use 61885) ~~(For revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator, use 0467T)~~	090	11.00 (No Change) (2021 Work RVU = 11.00)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(e)64570	-	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator (Do not report 64570 in conjunction with 61888) (For laparoscopic implantation, revision, replacement, or removal of vagus nerve blocking neurostimulator electrode array and/or pulse generator at the esophagogastric junction, see 0312T-0317T) ~~(For removal of chest wall respiratory sensor electrode or electrode array, use 0468T)~~	090	9.10 (No Change) (2021 Work RVU = 9.10)

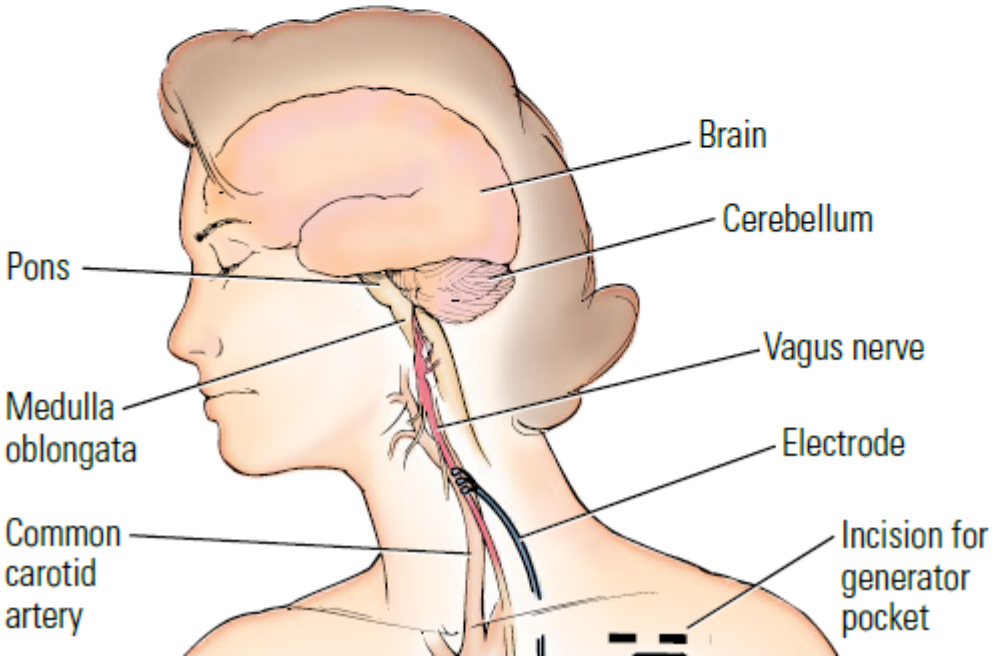
CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Implantation Neurostimulator Electrodes, Cranial Nerve (Vagus Nerve Stimulation)

64568-64570

lc - should read "Open implantation . . ."

Implantation of a cranial nerve (eg, vagus nerve) neurostimulator electrode with connection of the electrode to an implanted programmable pulse generator in the infraclavicular area (64568). Revision or replacement of the cranial nerve electrode (64569). Replacement of the cranial nerve pulse generator (61885).



CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(e)64575	-	~~Incision(s) for~~ Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	090	4.42 (No Change) (2021 Work RVU = 4.42)
(e)64580	-	neuromuscular	090	4.19 (No Change) (2021 Work RVU = 4.19)
(e)64581	-	sacral nerve (transforaminal placement)	090	12.20 (No Change) (2021 Work RVU = 12.20)
64585 *Revision or removal of peripheral neurostimulator electrode array*				

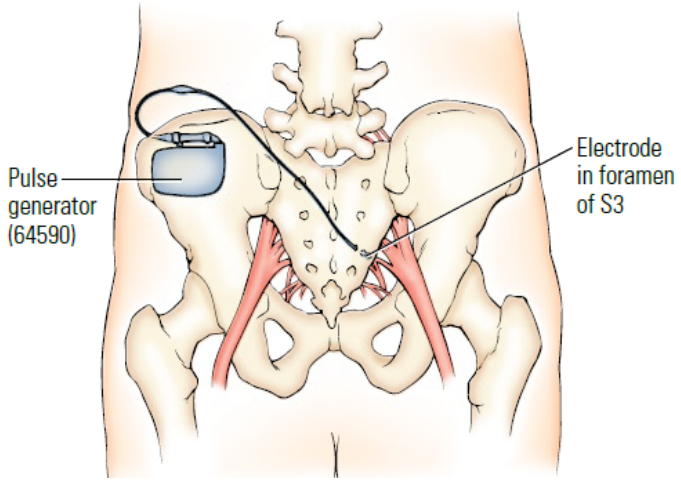
CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Open

~~Incisional~~ Implantation of Sacral Nerve Neurostimulator

64581

Posterior View



●64582	P1	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	090	16.00
●64583	P2	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator (Do not report 64583 in conjunction with 64582, 64584) (For revision or replacement of either the hypoglossal nerve stimulator electrode array or distal respiratory sensor, use modifier 52) (For replacement of pulse generator, use 61886)	090	16.50

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

●64584	P3	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array (Do not report 64584 in conjunction with 64582, 64583, 61888) (For removal of one or two components of the hypoglossal nerve stimulator electrode array, pulse generator, or distal respiratory sensor, use modifier 52)	090	14.00

Medicine
Neurology and Neuromuscular Procedures
Neurostimulators, Analysis-Programming

Electronic analysis of an implanted neurostimulator pulse generator/transmitter . . .

Codes 95971, 95972, 95976, 95977, 95983, 95984 are reported . . .

Test stimulations are typically performed during an implantation procedure (43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61880, 61885, 61886, 61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553, 64555, 64561, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64582, 64583, 64584, 64585, 64590, 64595) to confirm correct target site placement of the electrode array(s) and/or to confirm the functional status of the system. Test stimulation is not considered electronic analysis or programming of the neurostimulator system (test stimulation is included in the service described by the implantation code) and should not be reported with 95970, 95971, 95972, 95980, 95981, 95982, 95983, 95984. Electronic analysis of a device (95970) is not reported separately at the time of implantation.

(For insertion of neurostimulator pulse generator, see 61885, 61886, 63685, 64568, 64582, 64590)

(For revision or removal of neurostimulator pulse generator or receiver, see 61888, 63688, 64569, 64570, 64583, 64584, 64595)

(For implantation of neurostimulator electrodes, see 43647, 43881, 61850-~~*61870*~~*61868*, 63650, 63655, 64553-64581. For revision or removal of neurostimulator electrodes, see 43648, 43882, 61880, 63661, 63662, 63663, 63664, 64569, 64570, 64583, 64584, 64585)

(For analysis and programming of implanted integrated neurostimulation system, posterior tibial nerve, see 0589T, 0590T)

95970 *Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

	(Do not report 95970 in conjunction with 43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, ~~*61870,*~~ 61880, 61885, 61886, 61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553, 64555, 64561, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64582, 64583, 64584, 64585, 64590, 64595, during the same operative session) **Category III Codes**			
~~0466T~~	-	~~Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure)~~ ~~(Use 0466T in conjunction with 64568)~~	~~YYY~~	N/A
~~0467T~~	-	~~Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator~~ ~~(Do not report 0467T in conjunction with 0466T, 0468T)~~ ~~(For revision or replacement of cranial nerve [eg, vagus nerve] neurostimulator electrode array, including connection to existing pulse generator, use 64569)~~	~~YYY~~	N/A
~~0468T~~	-	~~Removal of chest wall respiratory sensor electrode or electrode array~~ ~~(Do not report 0468T in conjunction with 0466T, 0467T)~~ ~~(For removal of cranial nerve [eg, vagus nerve] neurostimulator electrode array and pulse generator, use 64570)~~ (0466T, 0467T, 0468T have been deleted) (To report insertion, revision or replacement, or removal of chest wall respiratory sensor electrode or electrode array, see 64582, 64583, 64584)	~~YYY~~	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64582 Tracking Number Original Specialty Recommended RVU: **16.00**
Presented Recommended RVU: **16.00**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **16.00**

CPT Descriptor: Open implantation of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46-year old male with moderate to severe obstructive sleep apnea presents after failing positive airway pressure thearpy, examination shows base of tongue airway collapse without complete concentric collapse at the palate.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 80% , In the ASC 20%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 83% , Overnight stay-less than 24 hours 17% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Description of Pre-Service Work: Meet with patients and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam. Reconcile medications and allergies. Address NPO status and timing. Discuss the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common complications. Discussion with the anesthesiologist regarding the anesthetic plan and the approximate length of the case. Review and obtain informed consent. The availability of all required instruments and supplies is verified. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The patient is positioned with care taken to ensure there is adequate exposure of the neck and chest. Given the typical body habitus of the patient undergoing a hypoglossal nerve stimulator, sleds are required in order to tuck both arms and allow for adequate surgical field exposure. The surgeon scrubs and gowns. Recording EMG needle electrodes are placed in the tongue musculature. The planned incision sites in both the neck and chest wall are prepped and draped in sterile fashion, then injected with local anesthetic.

Description of Intra-Service Work: An incision is made in the neck and brought through platysma and deep fascia; subplatysmal flaps are raised and the submandibular gland identified and retracted. The lingual nerve and marginal mandibular nerve are identified and preserved. Care is taken to achieve meticulous hemostasis to avoid injuries to these, as well as the contents of the carotid sheath. The posterior belly of the digastric muscle is identified and the carotid artery is identified through palpation. The hypoglossal nerve is identified by dissection through deep cervical fascia and followed distally until the branch(s) which extrude the tongue only through electrical stimulation are identified. A microscope is typically used to identify these distal branches. The stimulatory array is attached to these distal branch(s). The stimulatory array is secured to the digastric muscle.

• An upper chest incision is made and a pocket is created. The pulse generator is buried in its pocket and sewn to the pectoralis muscle. A tunnel is made between the hypoglossal lead and the upper chest incision. A horizontal incision is made in the lateral chest wall. Incision is taken through skin and subcutaneous tissue until the serratus anterior and pectoralis major muscles are identified. Dissection proceeds between these structures to the 6th intercostal space, identifying external and internal intercostal muscles. Blunt dissection extends between the intercostal muscles, avoiding the neurovascular bundle. A sensor lead is placed between the intercostal muscles and secured with multiple permanent sutures to the fascia overlying the chest wall.

A subcutaneous tunnel is created to connect the sensor lead incision to the generator pocket. The sensor lead is attached to the generator and respiratory sensing is verified. The sensor lead is repositioned if the sensor waveform is not adequate. All sites are irrigated. The surgical incisions are closed in a layered fashion and dressings are applied.

Description of Post-Service Work: The patient is observed during emergence from anesthesia. The procedure is dictated. Discharge medications are reconciled. The prescription drug monitoring database is reviewed. Postoperative orders, medications and instructions are written. There is a discussion with the family and patient regarding the procedure and findings. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review of the written postoperative instructions. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team.

Visit 1

A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. Sutures are removed. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. Extensive discussion regarding what to expect at the next visit, including activation of the device, occurs between the patient and the physician. The physician stresses the importance of the patient bringing the remote control with them to the next visit.

Visit 2

A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. The device is activated, which includes determining thresholds, impedance levels, sensing waveform, tongue motion, patient comfort, and programming patient control range. The patient is educated on understanding the remote control, practicing therapy use, and extent of the acclimation phase.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	64582					
Sample Size:	362	**Resp N:**	89			
Description of Sample:	Targeted, Research Subcommittee approved, sample of 362 industry trained Otolaryngologists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	6.00	**15.00**	25.00	100.00	
Survey RVW:	11.00	14.00	**16.00**	18.00	50.00	
Pre-Service Evaluation Time:			**35.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**14.00**			
Intra-Service Time:	45.00	120.00	**140.00**	180.00	258.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	64582	**Recommended Physician Work RVU: 16.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**35.00**	**40.00**	**-5.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**14.00**	**20.00**	**-6.00**
Intra-Service Time:		**140.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
38700	090	12.81	**RUC Time**

CPT Descriptor Suprahyoid lymphadenectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64911	090	14.00	**RUC Time**

CPT Descriptor Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.00	**RUC Time**	24,587

CPT Descriptor 1 Mastectomy, simple, complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
60500	090	15.60	**RUC Time**	18,921,573

CPT Descriptor 2 Parathyroidectomy or exploration of parathyroid(s);

Other Reference CPT Code	Global	Work RVU	Time Source
33621	090	16.81	**RUC Time**

CPT Descriptor Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 **% of respondents:** 21.3 **%**

Number of respondents who choose 2nd Key Reference Code: 17 **% of respondents:** 19.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 64582	Top Key Reference CPT Code: 38700	2nd Key Reference CPT Code: **64911**
Median Pre-Service Time	69.00	60.00	58.00
Median Intra-Service Time	140.00	90.00	110.00
Median Immediate Post-service Time	20.00	30.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	58.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	46.0	62.00	85.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**294.00**	**300.00**	**292.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	21%	47%	32%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	37%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	21%	79%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	32%	58%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	29%	41%	30%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	12%	24%	64%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	35%	59%
Physical effort required	6%	41%	53%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	35%	65%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting new codes 64582-84. These new codes represent implantation, revision/replacement, and removal of a hypoglossal nerve stimulator, previously reported using 64568-64570. The existing codes have been retained and now represent the same work when performed on the vagal nerve. Those services will predominantly by Neurosurgery and were not surveyed for this meeting as a

result of their changes being editorial. The Panel approved the CCA and the code is now being valued by the RUC. The new code will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted selection of 362 members from the American Academy of Otolaryngology – Head and Neck Surgery who self-designated in sleep medicine as their sub-specialty and are ***have also been trained through the mandatory process by the only company that currently manufactures this device, Inspire. Given that only Inspire trained physicians and facilities can perform this procedure at the time of survey, we did not feel it was appropriate or representative to survey sleep-medicine members who were not certified in these specific procedures.***

Recommendation (Work and Intra Time):

We are recommending a work RVU of **16.00 and 140 minutes of intra service time**, based on our survey's median RVW.

Time package selection: We have selected pre-time package 4 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia and the patients typically have multiple comorbities and being very difficult to position and access during the procedure.

Pre-time Package 4 Difficult Patient/Difficult Procedure

Evaluation Time – We are recommending 35 minutes of evaluation time which is 5 minutes less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 20 minutes of positioning time which is an increase of 17 minutes from the package time, but consistent with our survey median time and necessary for this procedure. Specifically, you must tape down the chest area to access the neck and utilize sleds and belts to secure them. There are two specific surgical sites and patients typically have a very large body habitus. The procedure requires that you have the ability to access them and position them in ergonomic fashion and requires an extended neck and chest access throughout the procedure.

Scrub, Dress, Wait Time – We are recommending 14 minutes of scrub, dress and wait time which is 6 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 69 minutes, taking the lesser of surveyed time or the pre-service package time with increased time requested for the extensive positioning work required for these procedures.

Post-time Package 9B General Anesthesia or Complex Regional Block/Complex Procedure
Recommended time has been reduced to 20 minutes which is a decrease of 13 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 20 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey supports this, with 59 respondents indicating that a discharge management visit is performed when the patient is discharged within 24 hours which is typical. Based on these results, we have included a **half discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. Both of these visits were indicated as a level three office visit, 99213.

Visit 1 - 99213
A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. Sutures are removed. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. Extensive discussion regarding what to expect at the next visit, including activation of the device, occurs between the patient and the physician. The physician stresses the importance of the patient bringing the remote control with them to the next visit.

Visit 2 - 99213
A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. The device is activated, which includes determining thresholds, impedance levels, sensing waveform, tongue motion, patient comfort, and programming patient control range. The patient is educated on understanding the remote control, practicing therapy use, and extent of the acclimation phase.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	2019 Medicare Utilization
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair	090	0.0892	15.00	120	271	2017-01	4370
60240	Thyroidectomy, total or complete	090	0.0682	15.04	150	327	2010-10	7157
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	090	0.0672	15.08	120	362	2007-09	1697
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	090	0.0469	15.11	120	439	2007-04	4868
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	090	0.0751	15.18	120	329	2008-02	1286
26250	Radical resection of tumor, metacarpal	090	0.0652	15.21	120	353	2009-02	11
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component	090	0.0517	15.50	120	418	2013-01	232
60500	Parathyroidectomy or exploration of parathyroid(s);	090	0.086	15.60	120	313	2010-10	18399
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	090	0.0942	15.60	120	271	2014-04	83
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)	090	0.0865	15.68	120	305	2017-01	5657
21935	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm	090	0.057	15.72	120	408	2009-02	235
24077	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm	090	0.0575	15.72	120	405	2009-02	223

27329	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm	090	0.056	15.72	120	413	2009-02	165
27615	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm	090	0.0555	15.72	120	416	2009-02	211
28445	Open treatment of talus fracture, includes internal fixation, when performed	090	0.0462	15.76	120	444	2007-02	447
27557	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair	090	0.0651	15.90	120	399	2007-04	14
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	090	0.0668	16.08	150	357	2007-04	569
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed;	090	0.0503	16.19	120	441	2007-02	1340
20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	090	0.0445	16.27	120	474	2007-04	3150
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	090	0.0768	16.41	120	365	2009-02	9
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	090	0.0569	16.56	120	429	2005-09	77
22904	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm	090	0.0673	16.69	120	396	2009-02	115
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	090	0.0786	16.84	150	344	2011-02	4804

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64568 and 0466T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 990
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume estimated below.

Specialty Otolaryngology Frequency 990 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 330
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is 33% of 64568's previous volume which is what we estimate will be transferred over to the new hypoglass nerve code 64582.

Specialty Otolaryngology Frequency 330 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 69930

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64583 Tracking Number Original Specialty Recommended RVU: **17.04**
Presented Recommended RVU: **16.50**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **16.50**

CPT Descriptor: Revision or replacement of hypoglossal nerve neruostimulator array and distal respiratory sensor electrode or electrode array, including connection to an existing pulse generator

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year old male who underwent placement of a hypoglossal nerve stimulator devleops a malfunctioning device. He undergoes replacement of the hypoglossal nerve neurostimulator electrode array, pulse generator, and distal respiratory sensor electrode or electrode array.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 75% , In the ASC 24%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 76% , Overnight stay-less than 24 hours 24% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 92%

Description of Pre-Service Work: Meet with patients and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam. Reconcile medications and allergies. Address NPO status and timing. Discuss the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common complications. Discussion with the anesthesiologist regarding the anesthetic plan and the approximate length of the case. Review and obtain informed consent. The availability of all required instruments and supplies is verified. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The patient is positioned with care taken to ensure there is adequate exposure of the neck and chest. Given the typical body habitus of the patient undergoing a hypoglossal nerve stimulator, sleds are required in order to tuck both arms and allow for adequate surgical field exposure. The surgeon scrubs and gowns. Recording EMG needle electrodes are placed in the tongue musculature. The planned incision sites in both the neck and chest wall are prepped and draped in sterile fashion, then injected with local anesthetic.

Description of Intra-Service Work: Incisions are made to access the stimulator array, chest wall sensor, and generator sites. Dissection proceeds to the sensor lead placed between the intercostal muscles. Once identified, the sensor is removed and its lead dissected from its subcutaneous tunnel to the generator pocket. The old sensor lead is detached from the generator and removed. The old generator is removed after it is disconnected from the stimulator array. The stimulator array is dissected free of the hypoglossal nerve carefully and replaced with a new stimulator array that is attached to the distal hypoglossal branches that only protrude the tongue as identified through direct stimulation. A microscope is typically utilized to visualize these distal branches. A new respiratory sensor is placed into the intercostal muscles and a new generator is placed into the previously created generator pocket. Both the new respiratory sensor and new stimulator array are attached to the pulse generator and the system is tested to ensure functional integrity. The wounds are irrigated. The surgical incisions are closed in a layered fashion and dressings are applied.

Description of Post-Service Work: The patient is observed during emergence from anesthesia. The procedure is dictated. Discharge medications are reconciled. The prescription drug monitoring database is reviewed. Postoperative orders, medications and instructions are written. There is a discussion with the family and patient regarding the procedure and findings. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course,

signs and symptoms of complications, and review of the written postoperative instructions. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team.

Visit 1:
A history is taken to evaluate the patients recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. Sutures are removed. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. Extensive discussion regarding what to expect at the next visit, including activation of the device, occurs between the patient and the physician. While the patient has been through this before, the discussion still occurs to ensure patient understanding. The physician stresses the importance of the patient bringing the remote control with them to the next visit.

Visit 2:
A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. The device is activated, which includes determining thresholds, impedance levels, sensing waveform, tongue motion, patient comfort, and programming patient control range. The patient is re-educated on understanding the remote control, practicing therapy use, and extent of the acclimation phase.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	64583					
Sample Size:	362	**Resp N:**	67			
Description of Sample:	Targeted, Research Subcommittee approved, sample of 362 industry trained Otolaryngologists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	1.00	6.00	
Survey RVW:	8.60	14.63	**16.50**	18.55	55.00	
Pre-Service Evaluation Time:			**40.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**14.00**			
Intra-Service Time:	30.00	120.00	**150.00**	180.00	288.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	64583	**Recommended Physician Work RVU: 16.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**20.00**	**3.00**	**17.00**
Pre-Service Scrub, Dress, Wait Time:		**14.00**	**20.00**	**-6.00**
Intra-Service Time:		**150.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
43420	090	16.78	**RUC Time**

CPT Descriptor Closure of esophagostomy or fistula; cervical approach

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
38700	090	12.81	**RUC Time**

CPT Descriptor Suprahyoid lymphadenectomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
58150	090	17.31	**RUC Time**	5,391

CPT Descriptor 1 Total Hysterectomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37215	090	17.75	**RUC Time**	10,340

CPT Descriptor 2 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

Other Reference CPT Code	Global	Work RVU	Time Source
15736	090	17.04	**RUC Time**

CPT Descriptor Muscle, myocutaneous, or fasciocutaneous flap; upper extremity

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 **% of respondents:** 20.8 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 20.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 64583	Top Key Reference CPT Code: 43420	2nd Key Reference CPT Code: **38700**
Median Pre-Service Time	74.00	90.00	60.00
Median Intra-Service Time	150.00	90.00	90.00
Median Immediate Post-service Time	20.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	248.00	58.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	46.0	62.00	62.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**309.00**	**520.00**	**300.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	14%	36%	50%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	29%	65%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	7%	93%
Physical effort required	0%	29%	72%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	21%	72%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	10%	20%	50%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	10%	80%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	20%	80%
Physical effort required	0%	10%	90%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	40%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting new codes 64582-84. These new codes represent implantation, revision/replacement, and removal of a hypoglossal nerve stimulator, previously reported using 64568-64570. The existing codes have been retained and now represent the same work when performed on the vagal nerve. Those services will predominantly by Neurosurgery and were not surveyed for this meeting as a

result of their changes being editorial. The Panel approved the CCA and the code is now being valued by the RUC. The new code will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted selection of 362 members from the American Academy of Otolaryngology – Head and Neck Surgery who self-designated in sleep medicine as their sub-specialty and are ***have also been trained through the mandatory process by the only company that currently manufactures this device, Inspire. Given that only Inspire trained physicians and facilities can perform this procedure at the time of survey, we did not feel it was appropriate or representative to survey sleep-medicine members who were not certified in these specific procedures.***

Recommendation (Work and Intra Time):

We are recommending a work RVU of **16.50 and 150 minutes of intra service time**, based on our survey's median RVW.

Time package selection: We have selected pre-time package 4 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia and the patients typically have multiple comorbities and being very difficult to position and access during the procedure.

Pre-time Package 4 Difficult Patient/Difficult Procedure

Evaluation Time – We are recommending 40 minutes of evaluation time which is consistent with the pre-service package time, and our survey median.

Positioning Time – We are recommending 20 minutes of positioning time which is an increase of 17 minutes from the package time, but consistent with our survey median time and necessary for this procedure. Specifically, you must tape down the chest area to access the neck and utilize sleds and belts to secure them. There are two specific surgical sites and patients typically have a very large body habitus. The procedure requires that you have the ability to access them and position them in ergonomic fashion and requires an extended neck and chest access throughout the procedure.

Scrub, Dress, Wait Time – We are recommending 14 minutes of scrub, dress and wait time which is 6 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 74 minutes, taking the lesser of surveyed time or the pre-service package time with increased time requested for the extensive positioning work required for these procedures.

Post-time Package 9B General Anesthesia or Complex Regional Block/Complex Procedure
Recommended time has been reduced to 20 minutes which is a decrease of 13 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 20 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey supports this, with 38 respondents indicating that a discharge management visit is performed when the patient is discharged within 24 hours which is typical. Based on these results, we have included a **half discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. Both of these visits were indicated as a level three office visit, 99213.

Visit 1 - 99213:
A history is taken to evaluate the patients recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. Sutures are removed. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. Extensive discussion regarding what to expect at the next visit, including activation of the device, occurs between the patient and the physician. While the patient has been through this before, the discussion still occurs to ensure patient understanding. The physician stresses the importance of the patient bringing the remote control with them to the next visit.

Visit 2 - 99213:
A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. The device is activated, which includes determining thresholds, impedance levels, sensing waveform, tongue motion, patient comfort, and programming patient control range. The patient is re-educated on understanding the remote control, practicing therapy use, and extent of the acclimation phase.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	2019 Medicare Utilization
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	090	0.0768	16.41	120	365	2009-02	9
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	090	0.0569	16.56	120	429	2005-09	77
22904	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm	090	0.0673	16.69	120	396	2009-02	115
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	090	0.0786	16.84	150	344	2011-02	4804
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity	090	0.0634	17.04	150	396	2016-04	1501
42415	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	090	0.0807	17.16	150	333	2011-02	5439
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	090	0.057	17.41	150	433	2000-08	61
28420	Open treatment of calcaneal fracture, includes internal fixation, when performed; with primary iliac or other autogenous bone graft (includes obtaining graft)	090	0.0476	17.52	150	481	2007-02	38
21740	Reconstructive repair of pectus excavatum or carinatum; open	090	0.0668	17.57	150	391	2002-04	15
60271	Thyroidectomy, including substernal thyroid; cervical approach	090	0.0715	17.62	150	377	2000-08	1670
35188	Repair, acquired or traumatic arteriovenous fistula; head and neck	090	0.0755	18.00	150	380	2010-10	13
27558	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair, with augmentation/reconstruction	090	0.0687	18.39	150	429	2007-04	15
27828	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of both tibia and fibula	090	0.0552	18.43	150	471	2007-02	1231
35184	Repair, congenital arteriovenous fistula; extremities	090	0.0737	18.82	150	413	2000-08	28

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64659 and 0467T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 614
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume estimated below.

Specialty Otolaryngology Frequency 614 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 205
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is 33% of 64569's previous volume which is what we estimate will be transferred over to the new hypoglass nerve code 64583.

Specialty Otolaryngology Frequency 205 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 69930

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64584 Tracking Number Original Specialty Recommended RVU: **14.00**
Presented Recommended RVU: **14.00**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **14.00**

CPT Descriptor: Removal of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year old male who underwent placement of a hypoglossal nerve stimulator devleops an intolerance to the system. He undergoes removal of the hypoglossal nerve neurostimulator electrode array, pulse gnerator, and distal respiratory sensor electrode or electrode array.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 75% , In the ASC 25%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 92% , Overnight stay-less than 24 hours 8% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Description of Pre-Service Work: Meet with patients and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam. Reconcile medications and allergies. Address NPO status and timing. Discuss the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common complications. Discussion with the anesthesiologist regarding the anesthetic plan and the approximate length of the case. Review and obtain informed consent. The availability of all required instruments and supplies is verified. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The patient is positioned with care taken to ensure there is adequate exposure of the neck and chest. Given the typical body habitus of the patient undergoing a hypoglossal nerve stimulator, sleds are required in order to tuck both arms and allow for adequate surgical field exposure. The surgeon scrubs and gowns. Recording EMG needle electrodes are placed in the tongue musculature. The planned incision sites in both the neck and chest wall are prepped and draped in sterile fashion, then injected with local anesthetic.

Description of Intra-Service Work: Incisions are made to access the stimulator array, chest wall sensor, and generator sites. Dissection proceeds to the sensor lead placed between the intercostal muscles. Once identified, the sensor is removed and its lead dissected from its subcutaneous tunnel to the generator pocket. The old sensor lead is detached from the generator and removed. The old generator is removed after it is disconnected from the stimulator array. The stimulator array is dissected free of the hypoglossal nerve carefully. The wounds are irrigated. The surgical incisions are closed in a layered fashion and dressings are applied.

Description of Post-Service Work: The patient is observed during emergence from anesthesia. The procedure is dictated. Discharge medications are reconciled. The prescription drug monitoring database is reviewed. Postoperative orders, medications and instructions are written. There is a discussion with the family and patient regarding the procedure and findings. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review of the written postoperative instructions. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team.

Visit 1:
A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. Sutures are removed. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. The patient and physician discuss the patients' current sleep history, including snoring, cessation of breathing and restless sleep. The physician inquires about any concerning signs of sleep apnea, including daytime somnolence.

Visit 2:
A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. The patient and physician discuss the patients' current sleep history, including snoring, cessation of breathing and restless sleep. The physician inquires about any concerning signs of sleep apnea, including daytime somnolence. The physician and the patient discuss further options for the treatment of sleep apnea given the absence of the hypoglossal nerve stimulator.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	64584					
Sample Size:	362	**Resp N:**	64			
Description of Sample:	Targeted, Research Subcommittee approved, sample of 362 industry trained Otolaryngologists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**0.00**	1.00	5.00	
Survey RVW:	8.00	12.00	**14.00**	16.00	45.00	
Pre-Service Evaluation Time:			**40.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	20.00	90.00	**120.00**	150.00	240.00	
Immediate Post Service-Time:	**20.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	64584	**Recommended Physician Work RVU: 14.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**33.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
60220	090	11.19	**RUC Time**

CPT Descriptor Total thyroid lobectomy, unilateral; with or without isthmusectomy

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
38700	090	12.81	**RUC Time**

CPT Descriptor Suprahyoid lymphadenectomy

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19303	090	15.00	**RUC Time**	24,587

CPT Descriptor 1 Mastectomy, simple, complete

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52649	090	14.56	**RUC Time**	4,687

CPT Descriptor 2 Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)

Other Reference CPT Code	Global	Work RVU	Time Source
58674	090	14.08	**RUC Time**

CPT Descriptor Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 17.1 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 15.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 64584	Top Key Reference CPT Code: 60220	2nd Key Reference CPT Code: **38700**
Median Pre-Service Time	70.00	72.00	60.00
Median Intra-Service Time	120.00	90.00	90.00
Median Immediate Post-service Time	20.00	40.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	58.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	46.0	46.00	62.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**275.00**	**267.00**	**300.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	9%	45%	45%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	18%	55%	27%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	36%	36%	27%
Physical effort required	18%	36%	45%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	27%	45%	27%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	10%	40%	25%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	50%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	10%	30%	60%
Physical effort required	10%	60%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	60%	10%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting new codes 64582-84. These new codes represent implantation, revision/replacement, and removal of a hypoglossal nerve stimulator, previously reported using 64568-64570. The existing codes have been retained and now represent the same work when performed on the vagal nerve. Those services will predominantly by Neurosurgery and were not surveyed for this meeting as a

result of their changes being editorial. The Panel approved the CCA and the code is now being valued by the RUC. The new code will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted selection of 362 members from the American Academy of Otolaryngology – Head and Neck Surgery who self-designated in sleep medicine as their sub-specialty and are ***have also been trained through the mandatory process by the only company that currently manufactures this device, Inspire. Given that only Inspire trained physicians and facilities can perform this procedure at the time of survey, we did not feel it was appropriate or representative to survey sleep-medicine members who were not certified in these specific procedures.***

Recommendation (Work and Intra Time):

We are recommending a work RVU of **14.00 and 120 minutes of intra service time**, based on our survey's median results.

Time package selection: We have selected pre-time package 4 and post-time package 9B due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia and the patients typically have multiple comorbities and being very difficult to position and access during the procedure.

Pre-time Package 4 Difficult Patient/Difficult Procedure

Evaluation Time – We are recommending 40 minutes of evaluation time which is consistent with the pre-service package time, and our survey median.

Positioning Time – We are recommending 15 minutes of positioning time which is an increase of 12 minutes from the package time, but consistent with our survey median time and necessary for this procedure. Specifically, you must tape down the chest area to access the neck and utilize sleds and belts to secure them. There are two specific surgical sites and patients typically have a very large body habitus. The procedure requires that you have the ability to access them and position them in ergonomic fashion and requires an extended neck and chest access throughout the procedure.

Scrub, Dress, Wait Time – We are recommending 15 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 70 minutes, taking the lesser of surveyed time or the pre-service package time with increased time requested for the extensive positioning work required for these procedures.

Post-time Package 9B General Anesthesia or Complex Regional Block/Complex Procedure
Recommended time has been reduced to 20 minutes which is a decrease of 13 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 20 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey supports this, with 44 respondents indicating that a discharge management visit is performed when the patient is discharged within 24 hours which is typical. Based on these results, we have included a **half discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. Both of these visits were indicated as a level three office visit, 99213. During visit one the physician checks the wound and removes sutures, ensuring there is no infection.

Visit 1 - 99213:
A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. Sutures are removed. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. The patient and physician discuss the patients' current sleep history, including

snoring, cessation of breathing and restless sleep. The physician inquires about any concerning signs of sleep apnea, including daytime somnolence.

Visit 2 - 99213:
A history is taken to evaluate the patients' recovery from surgery. The surgical wounds and implantation site are evaluated for any evidence of infection or dehiscense. A cranial nerve exam is performed with careful attention paid to the facial and hypoglossal nerve. The patient and physician discuss the patients' current sleep history, including snoring, cessation of breathing and restless sleep. The physician inquires about any concerning signs of sleep apnea, including daytime somnolence. The physician and the patient discuss further options for the treatment of sleep apnea given the absence of the hypoglossal nerve stimulator.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	2019 Medicare Utilization
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed	090	0.0506	13.15	120	361	2007-02	89
24545	Open treatment of humeral supracondylar or transcondylar fracture, includes internal fixation, when performed; without intercondylar extension	090	0.0506	13.15	120	361	2007-02	1389
36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	090	0.0755	13.29	120	283	2013-10	7456
43327	Esophagogastric fundoplasty partial or complete; laparotomy	090	0.0349	13.35	120	412	2010-04	111
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	090	0.0634	13.54	120	328	2008-02	2359
31591	Laryngoplasty, medialization, unilateral	090	0.0715	13.56	120	275	2016-01	1148
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	090	0.0766	13.76	120	298	2011-02	7253
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	090	0.0527	13.99	120	366	2009-10	7433
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	090	0.0825	14.08	120	266	2016-01	8
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	090	0.0748	14.17	120	306	2013-10	1949
36833	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	090	0.0775	14.50	120	306	2013-10	5657

52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	090	0.0831	14.56	120	279	2010-10	4687
31580	Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion	090	0.0283	14.60	120	405	2016-01	21
27217	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami)	090	0.0363	14.65	120	443	2008-04	
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)	090	0.0668	14.70	120	347	2005-08	13
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of tibia only	090	0.0387	14.79	120	441	2007-02	1167
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	090	0.0825	14.94	120	314	2011-02	5848
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair	090	0.0892	15.00	120	271	2017-01	4370

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64570 and 0468T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 83
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume estimated below.

Specialty Otolaryngology Frequency 83 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 27 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is 33% of 64570's previous volume which is what we estimate will be transferred over to the new hypoglass nerve code 64584.

Specialty Otolaryngology Frequency 27 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 69930

SS Rec Summary

ISSUE: Hypoglossal Nerve Stimulator Services

TAB: 13

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	FAC-inpt/same day 38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	38700	090	Suprahyoid lymphadenectomy	19	0.073	0.043			12.81			300	30	15	15			90			30					1	1.0							2	1						
2nd REF	64911	090	Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve	17	0.077	0.048			14.00			292	33	10	15			110			20						0.5							3	1						
CURRENT	64568	090	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator		0.038	0.033			9.00			275	33	3	15			90			30					1	1.0							2							
CURRENT	0466T	zzz	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure)																																					
SVY	64582	090	Open implantation of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	89	0.078	0.051	11.00	14.00	16.00	18.00	50.00	313	35	20	14	45	120	140	180	258	20						1.0							2					0	6	15	25	100
W/ Exp				88	0.088	0.058	11.00	14.00	16.00	18.00	50.00	275	34	20	15	45	120	140	180	258	20													2					1	6	15	25	100
W/out Exp				1	0.069	0.045	11.19	11.19	11.19	11.19	11.19	249	40	5	3			90			10						1.0							1	1						
REC	64582	090	Open implantation of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array		0.083	0.054			16.00			294	35	20	14			140			20						0.5							2							
1st REF	43420	090	Closure of esophagostomy or fistula; cervical approach	14	0.032	0.032			16.78			520	90					90			30			2	2	1	1.0							2	1						
2nd REF	38700	090	Suprahyoid lymphadenectomy	10	0.073	0.043			12.81			300	30	15	15			90			30					1	1.0							2	1						
CURRENT	64569	090	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator		0.044	0.035			11.00			312	40	3	15			120			30					1	1.0							2							
CURRENT	0467T	YYY	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator																																					
SVY	64583	090	Revision or replacement of hypoglossal nerve neruostimulator array and distal respiratory sensor electrode or electrode array, including connection to an existing pulse generator	67	0.076	0.050	8.60	14.63	16.50	18.55	55.00	328	40	20	14	30	120	150	180	288	20						1.0							2							
W/ Exp				38	0.085	0.057	8.60	15.00	16.55	18.68	55.00	289	40	20	13	60	120	150	180	288	20													2					1	1	1	2	6
W/out Exp				29	0.078	0.052	8.60	14.00	16.50	18.00	40.00	315	32	15	14	30	110	150	180	210	20						1.0							2							
REC	64583	090	Revision or replacement of hypoglossal nerve neruostimulator array and distal respiratory sensor electrode or electrode array, including connection to an existing pulse generator		0.080	0.053			16.50			309	40	20	14			150			20						0.5							2							
1st REF	60220	090	Total thyroid lobectomy, unilateral; with or without isthmusectomy	11	0.071	0.042			11.19			267	40	12	20			90			40						0.5							2							
2nd REF	38700	090	Suprahyoid lymphadenectomy	10	0.073	0.043			12.81			300	30	15	15			90			30					1	1.0							2	1						
CURRENT	64570	090	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator		0.037	0.032			9.10			282	40	3	15			90			30					1	1.0							2							
	0468T	YYY	Removal of chest wall respiratory sensor electrode or electrode array																																					
SVY	64584	090	Removal of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	64	0.075	0.048	8.00	12.00	14.00	16.00	45.00	294	40	15	15	20	90	120	150	240	20						1.0							2					0	0	0	1	5
W/ Exp				30	0.085	0.051	8.00	14.00	15.56	17.38	45.00	307	38	20	15	90	118	120	180	240	30						1.0							2					1	1	1	2	5
W/out Exp				34	0.083	0.049	8.85	11.16	12.25	15.00	25.00	252	35	15	10	20	60	90	150	180	18						1.0							2							
REC	64584	090	Removal of hypoglossal nerve neruostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array		0.080	0.051			14.00			275	40	15	15			120			20						0.5							2							

FACILITY DIRECT PE INPUTS **CPT CODE(S):_64582-84_____**
SPECIALTY SOCIETY(IES):____AAO-HNS
PRESENTER(S):___R. Peter Manes, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 20201

CPT Code	Long Descriptor	Global Period
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	090
CPT Code	**Long Descriptor**	**Global Period**
64583	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator	090
CPT Code	**Long Descriptor**	**Global Period**
64584	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64582	A 46-year-old male with moderate to severe obstructive sleep apnea presents after failing positive airway pressure therapy. Examination shows base of tongue airway collapse without complete concentric collapse at the palate.
CPT Code	**Vignette**
64583	A 48-year-old male who underwent placement of a hypoglossal nerve stimulator develops a malfunctioning device. He undergoes replacement of the hypoglossal nerve neurostimulator electrode array, pulse generator, and distal respiratory sensor electrode or electrode array.
CPT Code	**Vignette**
64584	A 48-year-old male who underwent placement of a hypoglossal nerve stimulator develops intolerance to the system. He undergoes removal of the hypoglossal nerve neurostimulator electrode array, pulse generator, and distal respiratory sensor electrode or electrode array.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialty formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisor and multiple clinical experts who practice in the areas of general otolaryngology and sleep medicine. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

These are new codes which represent procedures on the hypoglossal nerve only. Their volume will come out of existing codes which represented both vagal nerve and hypoglossal nerve procedures. Those codes are used as the reference. They are 64568, 64569, 64570.

3. Is this code(s) typically reported with an E/M service?
   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:
   N/A clinical staff time recommendations are identical to the prior code's PE inputs.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:
   N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:
   During the pre-service clinical staff are completing pre-service diagnostic and referral forms, coordinating pre-surgery services including test results, scheduling space and equipment in the facility, providing pre-service education and obtaining consent from the patient, and completing pre-procedure phone calls and prescriptions.
   b. Service period (includes pre, intra and post):
   N/A
   c. Post-service period:
   During the post service period two post-operative visits are scheduled during which the staff assist with the suture removal, ensure the patient bring s all needed equipment and supplies with them, and assists the physician in the activation and utilization of the device.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
   N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
   N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	U p
pack, post-op incision care (suture)	**SA054**	**pack**		4
kit, suture removal		kit	1	
povidone soln (Betadine)		ml	10	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	1	
steri-strip (6 strip uou)		item	2	
swab-pad, alcohol		item	2	
tape, surgical paper 1in (Micropore)		inch	12	
tincture of benzoin, swab		item	1	

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF008 Exam chair – office visit formula EQ170 Fiberoptic headlight – office visit formula

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

Clinical staff time remained unchanged except in the post period where post operative visit time went down.

Supplies were modified to remove unnecessary packs and add in only those items required, such as gloves. Supplies that were retained had quantities modified to reflect reduced numbers of visits.

Equipment remained unchanged, times modified in accordance with the office visit formula and reduced post operative visits.

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFEREN**
2						**CPT Code 64568**		**CPT Code 64582**		**CPT Co**
3		***RUC Collaboration Website***				Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator		Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array		Revision or of cranial vagus neurost electrode ar connection pulse g
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 68.48**	**$ -**	**$ 58.63**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**144.0**	**0.0**	**138.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**12.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**72.0**	**0.0**	**72.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 53.28**	**$ -**	**$ 51.06**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		5		5	
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		20		20	
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		8		8	
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37		20		20	
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		7		7	
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37					
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37					
23			L037D	RN/LPN/MTA	0.37					
26		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37					
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37					
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37					
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37					
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37					
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37					
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37					
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37					
42			L037D	RN/LPN/MTA	0.37					
45		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
48		**Intra-service (of service period)**								
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	L037D	RN/LPN/MTA	0.37					
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (63%)	L037D	RN/LPN/MTA	0.37					
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37					
55			L037D	RN/LPN/MTA	0.37					
56		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37					
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37					
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37					
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37					
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37					
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37					
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37					
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and key views	L037D	RN/LPN/MTA	0.37					
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	L037D	RN/LPN/MTA	0.37					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37					
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L037D	RN/LPN/MTA	0.37					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37					
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**	**12**	**n/a**	**6**	**n/a**
75			L037D	RN/LPN/MTA	0.37					
78		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37					
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37					
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27							
89		99213 36 minutes	36				2		2	
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**72.0**	**0.0**	**72.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37					
96		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFEREN**
2						**CPT Code 64568**		**CPT Code 64582**		**CPT Co**
3		***RUC Collaboration Website***				Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator		Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array		Revision or of cranial vagus neurost electrode ar connection pulse g
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 13 Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 68.48**	**$ -**	**$ 58.63**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**144.0**	**0.0**	**138.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**12.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**72.0**	**0.0**	**72.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 13.73**	**$ -**	**$ 5.68**	**$ -**
102	SA048	pack, minimum multi-specialty visit	4.0507	pack			2			
103	SA053	pack, post-op incision care (suture & staple)	5.63	pack			1			
104	SB022	gloves, non-sterile	0.246	pair					4	
105	SA054	pack, post-op incision care (suture)	4.6918	pack					1	
106										
107		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
109	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ 1.47**	**$ -**	**$ 1.90**	**$ -**
111	EF031	table, power	5968.4775	Office Visits	0.015838707		72			
112	EF014	light, surgical	2064.7828	Office Visits	0.00459289		72			
113	EF008	chair with headrest, exam, reclining	5565.6015	Office Visits	0.01238009				72.0	
114	EQ170	light, fiberoptic headlight w-source	3525.9372	Office Visits	0.013970455				72.0	
115										
116										
117		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	L	M	N	O	P	Q	R
1	RUC Practice Expense Spreadsheet		CE CODE	RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2			de 64569	CPT Code 64583		CPT Code 64570		CPT Code 64584	
3		***RUC Collaboration Website***	eplacement nerve (eg, nerve) mulator ay, including to existing enerator	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator		Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator		Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	
4	Clinical Activity Code	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAO-HNS**							
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 68.48**	**$ -**	**$ 58.63**	**$ -**	**$ 68.48**	**$ -**	**$ 58.63**
8		**TOTAL CLINICAL STAFF TIME**	**144.0**	**0.0**	**138.0**	**0.0**	**144.0**	**0.0**	**138.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**12.0**	**0.0**	**6.0**	**0.0**	**12.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**72.0**	**0.0**	**72.0**	**0.0**	**72.0**	**0.0**	**72.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 53.28**	**$ -**	**$ 51.06**	**$ -**	**$ 53.28**	**$ -**	**$ 51.06**
13		**PRE-SERVICE PERIOD**							
14		**Start: Following visit when decision for surgery/procedure made**							
15	CA001	Complete pre-service diagnostic and referral forms	5		5		5		5
16	CA002	Coordinate pre-surgery services (including test results)	20		20		20		20
17	CA003	Schedule space and equipment in facility	8		8		8		8
18	CA004	Provide pre-service education/obtain consent	20		20		20		20
19	CA005	Complete pre-procedure phone calls and prescription	7		7		7		7
20	CA006	Confirm availability of prior images/studies							
21	CA007	Review patient clinical extant information and questionnaire							
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)							
23									
26		*Other activity: please include short clinical description here and type new in column A*							
29		**End: When patient enters office/facility for surgery/procedure**							
30		**SERVICE PERIOD**							
31		**Start: When patient enters office/facility for surgery/procedure:**							
32		**Pre-Service (of service period)**							
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available							
34	CA010	Obtain vital signs							
35	CA011	Provide education/obtain consent							
36	CA012	Review requisition, assess for special needs							
37	CA013	Prepare room, equipment and supplies							
38	CA014	Confirm order, protocol exam							
39	CA015	Setup scope (nonfacility setting only)							
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient							
41	CA017	Sedate/apply anesthesia							
42									
45		*Other activity: please include short clinical description here and type new in column A*							
48		**Intra-service (of service period)**							
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)							
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (63%)							
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)							
52	CA021	Perform procedure/service---NOT directly related to physician work time							
55									
56		*Other activity: please include short clinical description here and type new in column A*							
59		**Post-Service (of service period)**							
60	CA022	Monitor patient following procedure/service, multitasking 1:4							
61	CA023	Monitor patient following procedure/service, no multitasking							
62	CA024	Clean room/equipment by clinical staff							
63	CA025	Clean scope							
64	CA026	Clean surgical instrument package							
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions							
66	CA028	Review/read post-procedure x-ray, lab and pathology reports							
67	CA029	Check dressings, catheters, wounds							
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,							
69	CA031	Review examination with interpreting MD/DO							
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to							
71	CA033	Perform regulatory mandated quality assurance activity (service period)							
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs,							
73	CA035	Review home care instructions, coordinate visits/prescriptions							
74	CA036	Discharge day management	**12**	**n/a**	**6**	**n/a**	**12**	**n/a**	**6**
75									
78		*Other activity: please include short clinical description here and type new in column A*							
81		**End: Patient leaves office/facility**							
82		**POST-SERVICE PERIOD**							
83		**Start: Patient leaves office/facility**							
84	CA037	Conduct patient communications							
85	CA038	Coordinate post-procedure services							
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes							
88		99212 27 minutes							
89		99213 36 minutes	2		2		2		2
90		99214 53 minutes							
91		99215 63 minutes							
92	CA039	Post-operative visits (total time)	**72.0**	**0.0**	**72.0**	**0.0**	**72.0**	**0.0**	**72.0**
93									
96		*Other activity: please include short clinical description here and type new in column A*							
99		**End: with last office visit before end of global period**							

	A	B	L	M	N	O	P	Q	R
1	**RUC Practice Expense Spreadsheet**		**CE CODE**	**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2			**de 64569**	**CPT Code 64583**		**CPT Code 64570**		**CPT Code 64584**	
3		***RUC Collaboration Website***		Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator					
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAO-HNS**	eplacement nerve (eg, nerve) mulator ay, including to existing enerator			Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator		Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 68.48**	**$ -**	**$ 58.63**	**$ -**	**$ 68.48**	**$ -**	**$ 58.63**
8		**TOTAL CLINICAL STAFF TIME**	**144.0**	**0.0**	**138.0**	**0.0**	**144.0**	**0.0**	**138.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**12.0**	**0.0**	**6.0**	**0.0**	**12.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**72.0**	**0.0**	**72.0**	**0.0**	**72.0**	**0.0**	**72.0**
100	**Supply Code**	**MEDICAL SUPPLIES**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 13.73**	**$ -**	**$ 5.68**	**$ -**	**$ 13.73**	**$ -**	**$ 5.68**
102	SA048	pack, minimum multi-specialty visit	2				2		
103	SA053	pack, post-op incision care (suture & staple)	1				1		
104	SB022	gloves, non-sterile			4				4
105	SA054	pack, post-op incision care (suture)			1				1
106									
107		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
109	**Equipment Code**	**EQUIPMENT**							
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 1.47**	**$ -**	**$ 1.90**	**$ -**	**$ 1.47**	**$ -**	**$ 1.90**
111	EF031	table, power	72				72		
112	EF014	light, surgical	72				72		
113	EF008	chair with headrest, exam, reclining			72.0				72.0
114	EQ170	light, fiberoptic headlight w-source			72.0				72.0
115									
116									
117		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*							

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Destruction of Intraosseous Basivertebral Nerve – Tab 14

In October 2020, the CPT Editorial Panel approved the addition of two codes to report thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance for the first two vertebral bodies (lumbar or sacral) and for each additional vertebral body (lumbar or sacral).

64628 ***Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral***
The RUC reviewed the survey results from 58 spine surgeons, physiatrists, and pain medicine physicians and determined that the survey median overestimated the work required to perform this service. After thorough discussion, the RUC recommends the survey 25th percentile work RVU of 8.25 to appropriately account for the physician work involved in this service. The RUC notes that the 25th percentile value results in a work intensity that closely aligns with the add-on code (0.085 and 0.081 IWPUT respectively). The RUC recommends: 56 minutes pre-service time (33 minutes evaluation, 10 minutes positioning, 13 minutes scrub/dress/wait time), 60 minutes intra-service time, and 20 minutes immediate post-service time, 0.5 99238 discharge visit and 1-99213 office visit.

The RUC noted that the survey 25th percentile value is appropriately bracketed by the two key reference service codes 22514 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar* (work RVU = 7.99 and 45 minutes intra-service time) and 22513 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic* (work RVU = 8.65 and 50 minutes intra-service time). The RUC concluded that CPT code 64628 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 8.25 for CPT code 64628.**

64629 ***Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 58 spine surgeons, physiatrists, and pain medicine physicians and determined that the survey 25th percentile work RVU of 4.87, intra-service and total time of 60 minutes, appropriately accounts for the physician work required to perform this add-on service. The RUC noted that the 25th percentile value results in a work intensity that closely aligns with the base code (0.081 and 0.085 IWPUT respectively).

The RUC also noted that there are several ZZZ codes with 60 minutes of intra-service time and similar work RVUs. Specifically, CPT code 61799 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)* (work RVU = 4.81 and 60 minutes intra-service time) and CPT code 63103 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure) (work RVU = 4.82 and 60 minutes intra-service time) are spinal/cranial procedures with similar amount of physician work and identical intra-service times. For further support, the RUC compared CPT code 64629 to the two key reference service codes 22515 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)* (work RVU = 4.00 and 30 minutes intra-service time) and 22552 *Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)* (work RVU = 6.50 and 45 minutes intra-service time) and agreed that these codes appropriately bracket the survey code. The RUC concluded that CPT code 64629 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 4.87 for CPT code 64629.**

Practice Expense
For CPT code 64628, the Practice Expense Subcommittee approved pre-service time for extensive use of clinical staff in the facility setting. The equipment inputs were modified to remove EQ168 *light, exam* and add EF031 *table, power*. For CPT code 64629, no direct practice expense inputs are recommended as the practice expense for the add-on code is already included in the base code. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology
CPT codes 64628 and 64629 will be placed on the New Technology list and will be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Nervous System **Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System** **Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency), Chemodenervation** **Somatic Nerves**				
●64628	Q1	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral (Use 64628 in conjunction with 64629)	010	8.25
✚●64629	Q2	each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure) (Do not report 64628, 64629 in conjunction with 77003, 77012)	ZZZ	4.87

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64628 Tracking Number Original Specialty Recommended RVU: **9.75**
Presented Recommended RVU: **9.75**
Global Period: 010 Current Work RVU: **N/A** RUC Recommended RVU: **8.25**

CPT Descriptor: Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female with more than 6 months of chronic axial low back pain who failed a minimum of 6 months of traditional conservative therapies, including active physical therapy or chiropractic care, spinal injections and/or medications. An MRI demonstrates degenerative disc disease at L5-S1 with associated endplate changes consistent with Modic Type I in the L5 and S1 vertebral bodies.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 68% , In the ASC 28%, In the office 4%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 95% , Overnight stay-less than 24 hours 5% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Description of Pre-Service Work: Review records and any pertinent imaging studies. Confirm (THE NEGATIVE) results of (the-REMOVE) diagnostic facet injections with patient. Communicate with other professionals, patient, and family, and obtain informed consent. Dress, scrub, and wait before the procedure. Prepare patient and needed equipment for the procedure. Position the patient on the X-ray table for appropriate fluoroscopic view. Prepare the skin and drape the ablation site.

Description of Intra-Service Work: An incision is made, and an introducer trocar is inserted with a mallet to access the vertebral body via a transpedicular approach. After breaching the posterior vertebral body with the trocar at the junction of the pedicle and vertebral body, a curved cannula assembly is utilized within the vertebral body and navigate towards the basivertebral nerve, which is located in the posterior 1/3 of the vertebral body. A straight channeling stylet is then utilized if needed to extend the channel to the midline location of the basivertebral nerve. The straight channeling stylet is then removed. Once accurate placement is confirmed, a bipolar probe is inserted into the posterior half of the vertebral body, connected to the radiofrequency generator, and radiofrequency energy is applied for 15 minutes to destroy the basivertebral nerve. The next vertebral body is accessed sequentially using the same technique with additional instrumentation required. Energy is applied for 15 minutes to destroy the basivertebral nerve in this adjacent vertebral body. At the completion of the procedure, all instruments are removed, and the incisions are closed.
Report 64628 for destruction of the intraosseous basivertebral nerve within two consecutive vertebral bodies (1 motion segment); report 64629 for each additional destruction of intraosseous basivertebral nerve within each additional vertebral body.

Description of Post-Service Work: After the procedure, observe the patient for any new and unexpected neurological deficits. Review the procedure and results (including written and telephone reports and orders) with the patient and other professionals. Schedule an office visit within the ten-day global period to monitor for complications, assessment of pain and pain relief, and documentation of functional outcome are included in the medical chart.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Gregory Polston, MD; David Reese, MD; Carlo Milani, MD; Kano Myer, MD; Karin Swartz, MD; Wesley Ibazebo, MD; Graham Wagner, MD; Morgan Lorio, MD; Michael Lubrano, MD					
Specialty Society(ies):	AAPM, AAPM&R, NASS, ISASS, SIS, ASIPP					
CPT Code:	64628					
Sample Size:	1364	**Resp N:**	58			
Description of Sample:	Random Sample of Surveying Societies and Targeted Survey of Device Manufacturer Trained Physician List					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	5.00	36.00
Survey RVW:	1.50	8.25	**9.75**	17.23	39.95
Pre-Service Evaluation Time:			**44.00**		
Pre-Service Positioning Time:			**10.00**		
Pre-Service Scrub, Dress, Wait Time:			**13.00**		
Intra-Service Time:	10.00	45.00	**60.00**	90.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	64628	**Recommended Physician Work RVU: 8.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**10.00**	**3.00**	**7.00**
Pre-Service Scrub, Dress, Wait Time:		**13.00**	**15.00**	**-2.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**30.00**	**-10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	19.00	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	23.00	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22514	010	7.99	**RUC Time**

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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22513	010	8.65	**RUC Time**

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

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64561	010	5.44	**RUC Time**	14,987

CPT Descriptor 1 Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
50592	010	6.55	**RUC Time**	1,589

CPT Descriptor 2 Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency

Other Reference CPT Code	Global	Work RVU	Time Source
31239	010	9.04	**RUC Time**

CPT Descriptor Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 34 **% of respondents:** 58.6 **%**

Number of respondents who choose 2nd Key Reference Code: 21 **% of respondents:** 36.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 64628	Top Key Reference CPT Code: 22514	2nd Key Reference CPT Code: **22513**
Median Pre-Service Time	56.00	43.00	43.00
Median Intra-Service Time	60.00	45.00	50.00
Median Immediate Post-service Time	20.00	20.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	23.0	23.00	23.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**178.00**	**150.00**	**155.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	22%	42%	36%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	19%	62%
Physical effort required	3%	25%	72%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	25%	66%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	20%	50%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making		15%	85%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	40%	55%
Physical effort required	15%	35%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	15%	85%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Codes 64628 and 64629 were established at the CPT Editorial Panel Meeting in October 2020 to report ablation of the interosseous basivertebral nerve. These new codes were then placed on the RUC New/Revised Level of Interest Form. Multiple societies responded with an interest in surveying.

64628 was given a global period of 010 days and 64629 was given a global period of ZZZ as an add-on code.

AAPM, AAPM&R, ASIPP, NASS, SIS, and ISASS conducted random samples of their members. In addition, the specialties requested permission from the RUC Research Subcommittee to additionally include trained physicians from a list provided by the device manufacturer Relievant Inc.

A total of 1364 survey requests were sent out, with 290 going to the targeted survey list provided by Relievant. A total of 58 non-financially conflicted surveys were completed.

The median experience rate for the surveyed procedure in the last 12 months was 2.

Survey Results

Pre-Service:

- Median Pre-Service Evaluation time=44 minutes
- Median Pre-Service Positioning time=10 minutes
- Median Pre-Service Scrub, Dress and Wait time=13 minutes

Intra-Service:

- Median Intra-service time=60 minutes

Immediate Post-Service:

- Median Immediate post-service time=20 minutes

Post-Service Visits:

- Median Facility Visits=.50 99238 (same day discharge)
- Median Non-Facility Visits=2 99213 (Level III Office/Outpatient E/M visits)

Total Survey Time: 212 minutes

Survey Work RVU

- 25th % Work RVU=8.25
- Median Work RVU=9.75
- 75th% Work RVU=17.23

Key Reference Services

Survey respondents choose CPT code 22514, Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar as the primary key reference code with 34 respondents choosing it as the KRS. CPT code 22513, Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic was the second key reference service, chosen by 21 of the survey respondents.

Recommended Time and Work RVU

A consensus panel of RUC advisors from the surveying specialties met and recommend the following time and work RVU for CPT code 64628.

Pre-Service Package 3 Straightforward Patient/Difficult Procedure:

- Median Pre-Service Evaluation time=33 minutes (standard package pre-service evaluation time)
- Median Pre-Service Positioning time=10 minutes (standard package pre-service positioning time, plus 7 minutes to account for time spent positioning patient prone; survey median time)
- Median Pre-Service Scrub, Dress and Wait time=13 minutes (standard package pre-service SDW time, minus 7 minutes to equal survey median time)

Intra-Service:

- Median Intra-service time=60 minutes

Immediate Post-Service Package 9A General Anesthesia or Regional Block/Straightforward Procedure):

- Median Immediate post-service time=20 minutes (standard package immediate post-service time minus 10 minutes to equal survey median time)

Post-Service Visits:

- Median Facility Visits=.50 99238 (same day discharge)
- Median Non-Facility Visits=1 99213 (Level III Office/Outpatient E/M visit). The consensus panel felt that 1 post-operative visit in the 10-day global period was more typical than 2, as indicated by the survey respondents. 1 post-operative visit is also consistent with the post-operative visits for key reference services 22514 and 22513

Total Survey Time: 178 minutes

Work RVU=9.75 (median survey work RVU).

The Consensus Panel felt the survey median work RVU of 9.75 to be an appropriate work RVU for 64628. 9.75 was the median work RVU from the survey which we believe is an accurate reflection of physician work and intensity as indicated by the survey respondents and the fact they have experience with the procedure. A work RVU of 9.75 has an IWPUT of .110 which is almost exactly equal to the KRS code 22514 IWPUT of .112 and the second KRS code of 22513 with an IWPUT of .114. Thus, a work RVU of 9.75 maintains relativity with the key comparison procedures as indicated by survey respondents. Our survey respondents ranked 64628 as more complex and intense than both 22513 and 22514 for all measures, with more than 50% of respondents indicating 64628 to be more complex for all components of the procedure

The Consensus Panel also compared 64628 to other 010 global periods. CPT code 31239, Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy which was RUC valued in 2013, has the same intra-service time of 60 minutes, and similar post-operative visits of 0.5 99238 and a 99213 office visit, total time of 168 minutes and a work RUV of 9.04. The Panel believes 64628 to be slightly more intense in its work than this endoscopy procedure, but otherwise very similar in nature.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. As the base code, 64628 would be reported with 660X1, the add-on code when 64629 is performed. The October 2020 CPT Code Change Proposal estimated that 6462 would be reported approximately 11% of the time that 64628 is reported.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22899

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pain Medicine How often? Sometimes

Specialty Physical Medicine and Rehabilitation How often? Sometimes

Specialty Interventional Pain How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 900
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated by consensus panel

Specialty Pain Medicine Frequency 200 Percentage 22.22 %

Specialty Physical Medicine and Rehabilitation Frequency 100 Percentage 11.11 %

Specialty Inteventional Pain Frequency 200 Percentage 22.22 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 800
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated by consensus panel

Specialty Pain Medicine Frequency 175 Percentage 21.87 %

Specialty Physical Medicine and Rehabilitation Frequency 175 Percentage 21.87 %

Specialty Interventional Pain Frequency 135 Percentage 16.87 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 63650

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64629 Tracking Number Original Specialty Recommended RVU: **4.87**
Presented Recommended RVU: **4.87**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **4.87**

CPT Descriptor: Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)
(Do not report 64628, 64629 in conjunction with 77003, 77012)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female with more than 6 months of chronic axial low back pain who failed a minimum of 6 months of traditional conservative therapies, including active physical therapy or chiropractic care, spinal injections and/or medications. An MRI demonstrates degenerative disc disease at L5-S1 with associated endplate changes consistent with Modic Type I in the L5 and S1 vertebral bodies. Note: This is an add-on service. Only consider the additional work related to the primary procedure.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day , Overnight stay-less than 24 hours , Overnight stay-more than 24 hours

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day

Description of Pre-Service Work: N/A

Description of Intra-Service Work: An incision is made, and an introducer trocar is inserted with a mallet to access the vertebral body via a transpedicular approach. After breaching the posterior vertebral body with the trocar at the junction of the pedicle and vertebral body, a curved cannula assembly is utilized within the vertebral body and navigate towards the basivertebral nerve, which is located in the posterior 1/3 of the vertebral body. A straight channeling stylet is then utilized if needed to extend the channel to the midline location of the basivertebral nerve. The straight channeling stylet is then removed. Once accurate placement is confirmed, a bipolar probe is inserted into the posterior half of the vertebral body, connected to the radiofrequency generator, and radiofrequency energy is applied for 15 minutes to destroy the basivertebral nerve. The next vertebral body is accessed sequentially using the same technique with additional instrumentation required. Energy is applied for 15 minutes to destroy the basivertebral nerve in this adjacent vertebral body. At the completion of the procedure, all instruments are removed, and the incisions are closed.
Report 64628 for destruction of the intraosseous basivertebral nerve within two consecutive vertebral bodies (1 motion segment); report 64629 for each additional destruction of intraosseous basivertebral nerve within each additional vertebral body.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Gregory Polston, MD; David Reese, MD; Carlo Milani, MD; Kano Myer, MD; Karin Swartz, MD; Wesley Ibazebo, MD; Graham Wagner, MD; Morgan Lorio, MD; Michael Lubrano, MD					
Specialty Society(ies):	AAPM, AAPM&R, NASS, ISASS, SIS, ASIPP					
CPT Code:	64629					
Sample Size:	1364	**Resp N:**	58			
Description of Sample:	Random Sample of Societies & Targeted Survey of Device Manufacturer Trained Physicians					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	6.00	30.00
Survey RVW:	1.50	4.75	**7.00**	10.00	20.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	40.00	**60.00**	90.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	64629	**Recommended Physician Work RVU: 4.87**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

Select Post-Service Package

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22515	ZZZ	4.00	**RUC Time**

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

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22552	ZZZ	6.50	**RUC Time**

CPT Descriptor Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.87	**RUC Time**	128,927

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 2 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
63103	ZZZ	4.82	**RUC Time**

CPT Descriptor Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 47 **% of respondents:** 81.0 **%**

Number of respondents who choose 2nd Key Reference Code: 2 **% of respondents:** 3.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 64629	Top Key Reference CPT Code: 22515	2nd Key Reference CPT Code: **22552**
Median Pre-Service Time	0.00	1.00	5.00
Median Intra-Service Time	60.00	30.00	45.00
Median Immediate Post-service Time	0.00	1.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**32.00**	**50.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	20%	48%	32%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	27%	73%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	18%	80%
Physical effort required	2%	25%	73%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	36%	59%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	100%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	100%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	100%	0%
Physical effort required	0%	100%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	100%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Codes 64628 and 64629 were established at the CPT Editorial Panel Meeting in October 2020 to report ablation of the interosseous basivertebral nerve. These new codes were then placed on the RUC New/Revised Level of Interest Form. Multiple societies responded with an interest in surveying.

64628 was given a global period of 010 days and 64629 was given a global period of ZZZ as an add-on code.

AAPM, AAPM&R, ASIPP, NASS, SIS, and ISASS conducted random samples of their members. In addition, the specialties requested permission from the RUC Research Subcommittee to additionally include trained physicians from a list provided by the device manufacturer Relievant Inc.

A total of 1364 survey requests were sent out, with 290 going to the targeted survey list provided by Relievant. A total of 58 non-financially conflicted surveys were completed.

The median experience rate for the surveyed procedure in the last 12 months was 2.

Survey Results

Intra-Service:

- Median Intra-service time=60 minutes

Total Survey Time: 212 minutes

Survey Work RVU

- 25th % Work RVU=4.87
- Median Work RVU=7.00
- 75th% Work RVU=10.00

Key Reference Services

Survey respondents choose CPT code 22515, Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) as the primary key reference code with 53 respondents (81%) choosing it as the KRS. Multiple other reference services were chosen by 2 respondents, but none was chosen by more than 2 additional respondents.

Recommended Time and Work RVU

A consensus panel of RUC advisors from the surveying specialties met and recommend the following time and work RVU for CPT code 64629

Intra-Service:

- Median Intra-service time=60 minutes

Total Survey Time: 60 minutes

Work RVU=4.87 (25th % survey work RVU).

The Consensus Panel felt the survey 25th % work RVU of 4.87 to be an appropriate work RVU for 64629. 4.87 was the 25th % work RVU from the survey which we believe is an accurate reflection of physician work and intensity as indicated by the survey respondents and the fact they have experience with the procedure. A work RVU of 4.87 maintains appropriate relativity with the base code of 64628 at the recommended work RVU of 9.75 as 64629 has no pre or post work included and should be approximately 50% of the base code work RVU. The Consensus Panel felt the survey median work RVU of 7.00 would be too high relative to 64628 and not represent an appropriate reduction in work RVU relative to the reduced total times.

The 25th % survey work RVU of 4.87 is also more appropriately relative to the work RVU for the KRS of 22515 at 4.00 and has a similar reduction in work RVU to the base codes for 22515 (22513 and 22513). Thus, a work RVU of 4.87 maintains appropriate relativity with the work RVUs for the family of Key Reference Services with an IWPUT considerably lower than KRS 22515 suggesting 4.87 falls on the lower end of the range of appropriate work RVU for 64629.

In addition, the Consensus Panel also compared 64629 to other ZZZ global period codes. There are several ZZZ codes with 60 minutes of intra-time and similar work RVUs. Specifically, CPT code 61799, CPT code 63103 and CPT code 22854. All three have been RUC surveyed, all are spinal/cranial procedures, and 61799 and 63103 having almost identical WRVUS. 22854 has a significantly higher RVW even with the same 60 minutes of intra-service time.

CPT CODE	DESCRIPTOR	WORK RVU	INTRA-SERVICE TIME	TOTAL TIME	IWPUT
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	4.00	30	32	.132
61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)	4.81	60	60	.080
63103	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)	4.82	60	60	.080
64629	**Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)**	**4.87**	**60**	**60**	**.081**
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	5.50	60	60	.092

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. As the add-on code, 64629 would be reported with 64628, the base code when performed. The October 2020 CPT Code Change Proposal estimated that 64629 would be reported approximately 11% of the time that 64628 is reported

---

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22899

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pain Management How often? Sometimes

Specialty Interventional Pain Management How often? Sometimes

Specialty Physical Medicine and Rehabilitation How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Consensus Panel estimate

Specialty Pain Management Frequency 50 Percentage 25.00 %

Specialty Interventional Pain Management Frequency 50 Percentage 25.00 %

Specialty Physical Medicine and Rehabilitation Frequency 25 Percentage 12.50 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Consensus Panel Estimate

Specialty Pain Management Frequency 25 Percentage 25.00 %

Specialty Interventional Pain Management Frequency 25 Percentage 25.00 %

Specialty Physical Medicine and Rehabilitation Frequency 13 Percentage 13.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64634

ISSUE: Destruction of Interosseous Basivertebral Nerve
TAB: 14

OVERALL

							RVW					Total	PRE			INTRA					POST					POST-OFFICE			12 Month Svy Experience					
SOURCE	CPT	Glob	DESC	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	32	31	38	39	14	13	12	MIN	25th	MED	75th	MAX	TYP?
REF1	22514	10	Percutaneous vertebral augmentation, includi	34	0.112	0.053			7.99			150	23	15	5			45			20			0.5			1							
REF2	22513	10	Percutaneous vertebral augmentation, includi	21	0.114	0.056			8.65			155	23	15	5			50			20			0.5			1							
SVY	64628	10	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral	58	0.090	0.046	1.50	8.25	9.75	17.23	39.95	212	44	10	13	10	45	60	90	120	20			0.5			2		0	0	2	5	36	100%
REC	64628	10	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral		0.085	0.046			8.25			178	33	10	13			60			20			0.5			1							

							RVW					Total	PRE			INTRA					POST					POST-OFFICE			12 Month Svy Experience					
SOURCE	CPT	Glob	DESC	Resp	IWPUT	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	32	31	38	39	14	13	12	MIN	25th	MED	75th	MAX	TYP?
REF1	22515	ZZZ	Percutaneous vertebral augmentation, includi	47	0.132	0.125			4.00			32		1				30			1													
REF2	22552	ZZZ	Arthrodesis, anterior interbody, including disc	2	0.142	0.130			6.50			50		5				45																
SVY	64629	ZZZ	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)	58	0.117	0.117	1.50	4.87	7.00	10.00	20.00	60				10	40	60	80	180									0	0	2	6	30	93%
REC	64629	ZZZ	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; each additional vertebral body, lumbar or sacral		0.081	0.081			4.87			60						60																

FACILITY DIRECT PE INPUTS **CPT CODE(S):_64628, 64629_____**

SPECIALTY SOCIETY(IES):__NASS, SIS, AAPM&R, AAPM, ASIPP, ISASS_____

PRESENTER(S):__Karin Swartz, MD; Kano Myer, MD; Wesley Ibazebo, MD; Graham Wagner, MD; David Reese, MD; Carlo Milani, MD; Gregory Polston, MD; Michael Labrano, MD; Morgan Lorio, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
64628	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral	010
64629	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure) (Do not report 64628, 64629 in conjunction with 77003, 77012)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64628	A 50-year-old female with more than 6 months of chronic axial low back pain who failed a minimum of 6 months of traditional conservative therapies, including active physical therapy or chiropractic care, spinal injections and/or medications. An MRI demonstrates degenerative disc disease at L5-S1 with associated endplate changes consistent with Modic Type I in the L5 and S1 vertebral bodies.
64629	A 50-year-old female with more than 6 months of chronic axial low back pain who failed a minimum of 6 months of traditional conservative therapies, including active physical therapy or chiropractic care, spinal injections and/or medications. An MRI demonstrates degenerative disc disease at L5-S1 with associated endplate changes consistent with Modic Type I in the L5 and S1 vertebral bodies. Note: This is an add-on service. Only consider the additional work related to the primary procedure.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our Committee Expert Panel reviewed the code descriptors and typical patients and developed consensus recommendations for clinical staff time, equipment, and supplies. The panel recommends standard 010 global facility inputs for 64628 with no additional time or equipment. The panel recommends standard ZZZ facility inputs of 0 for 64629

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   64628 KRS-22514: Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar

FACILITY DIRECT PE INPUTS **CPT CODE(S):_64628, 64629_____**

SPECIALTY SOCIETY(IES):__NASS, SIS, AAPM&R, AAPM, ASIPP, ISASS_____

PRESENTER(S):__Karin Swartz, MD; Kano Myer, MD; Wesley Ibazebo, MD; Graham Wagner, MD; David Reese, MD; Carlo Milani, MD; Gregory Polston, MD; Michael Labrano, MD; Morgan Lorio, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

64629 KRS-22515: Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

   Clinical staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is available for a ride home and answers patient questions.

   b. Service period (includes pre, intra and post):

   Clinical staff will be available throughout the procedure to circulate and provide clean supplies and instruments, assist with equipment needs, and assist with maintaining patient's extremity position or repositioning.

   c. Post-service period:

   Standard clinical staff work during post-op office follow up visits

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

   N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

   N/A

FACILITY DIRECT PE INPUTS **CPT CODE(S):_64628, 64629_____**

SPECIALTY SOCIETY(IES):__NASS, SIS, AAPM&R, AAPM, ASIPP, ISASS_____

PRESENTER(S):__Karin Swartz, MD; Kano Myer, MD; Wesley Ibazebo, MD; Graham Wagner, MD; David Reese, MD; Carlo Milani, MD; Gregory Polston, MD; Michael Labrano, MD; Morgan Lorio, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

no

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EQ168	light, exam	1332.1952	0.003535282	36	36	36
EF031	table, power	5968.4775	0.015838707	36	36	36

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

The consensus panel recommends 30 minutes pre-service clinical staff inputs. The PE subcommittee has a standard of 0 minutes for pre-service clinical staff work for 010 global period codes such as

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

64628. 64628 however is not a typical 010 global period procedure. It is an extensive procedure, more similar to a typical 090-day global period procedure (which is assigned 60 minutes clinical pre-service time as a standard) than many more "minor" 010 global period procedures such as injections. 64628 is performed in a facility only, and under general anesthesia. It requires extensive clinical staff work in advance of the procedure to complete diagnostic and referral forms, completed pre-surgical checklists, schedule equipment for the facility, obtain consent and complete consent forms and phone calls including prescription setup/ordering. Clinical staff are essential in the pre-service period and are engaged extensively. 30 minutes of pre-service clinical staff time is an appropriate assignment for 64628 and matches the KRS 22514 pre-service clinical staff allocation. 22514, Kyphoplasty is similar in its setting and pre-service work requirements and the 30 minutes pre-service clinical staff time maintains that relativity appropriately.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K
1	RUC Practice Expense Spreadsheet					REFERENCE CODE		RECOMMENDED		REFEREN
2						CPT Code 22514		CPT Code 64628		CPT Cod
3		***RUC Collaboration Website***				Percutaneous vertebral augmentation, including cavity creation (fracture		Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance;		Percutaneou augmen including creation (
4	Clinical Activity Code	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 14 Specialty: NASS, SIS, AAPM, AAPM&R, ASIPP, ISASS**	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**010**	**010**	**010**	**010**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 4,458.06**	**$ 31.39**	**$ -**	**$ 31.26**	**$ 2,352.68**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**170.0**	**72.0**	**0.0**	**72.0**	**60.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**30.0**	**0.0**	**30.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**116.0**	**6.0**	**0.0**	**6.0**	**60.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**36.0**	**36.0**	**0.0**	**36.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 65.12**	**$ 26.64**	**$ -**	**$ 26.64**	**$ 23.40**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	5	5		5	
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37	3	10		10	
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		5		5	
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	7	7		7	
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3	3		3	
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37					
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33			L037D	RN/LPN/MTA	0.37					
34	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37	3				
35	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5				
36	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37					
37	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37					
38	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	5				
39	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37					
40	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37					
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	3				
42	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37					
45		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
48		**Intra-service (of service period)**								
49			L037D	RN/LPN/MTA	0.37					
50	CA018	Assist physician or other qualified healthcare professional--directly related to physician work time (67%)	L037D	Radiologic Technologist	0.37	45				
51	CA018	Assist physician or other qualified healthcare professional--directly related to physician work time (33%)	L037D	Radiologic Technologist	0.37					30
52	CA019	Assist physician or other qualified healthcare professional--directly related to physician work time (67%)	L037D	RN/LPN/MTA	0.37					
53	CA019	Assist physician or other qualified healthcare professional--directly related to physician work time (33%)	L037D	RN/LPN/MTA	0.37					
56	CA020	Assist physician or other qualified healthcare professional--directly related to physician work time (other%)	L041B	RN/LPN/MTA	0.41					7
57	CA020	Assist physician or other qualified healthcare professional--directly	L041C	Radiologic Technologist	0.41	38				23
58	CA021	Perform procedure/service---NOT directly related to physician work time	L051A	RN	0.51	5				0
59		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
62		**Post-Service (of service period)**								
63		Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37					
64	CA022	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37					
65	CA023	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37					
66	CA024	Clean scope	L037D	RN/LPN/MTA	0.37	3				
67	CA025	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37					
68	CA026	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37					
69	CA027	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37	2				
70	CA028	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	2				
71	CA029	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37	5				
72	CA030	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37					
73	CA031	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37					
74	CA032	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37					
75	CA033	Document procedure (non-PACS) (e.g. mandated reporting, registry logs,	L037D	RN/LPN/MTA	0.37					
76	CA034	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37					
77	CA035	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**
78	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37		**6**		**6**	
81		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
84		**End: Patient leaves office/facility**								
85		**POST-SERVICE PERIOD**								
86		**Start: Patient leaves office/facility**								
87		Conduct patient communications	L037D	RN/LPN/MTA	0.37					
88	CA037	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37					
89	CA038	***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
90		99211 16 minutes	16							
91		99212 27 minutes	27							
92		99213 36 minutes	36			1	1		1	
93		99214 53 minutes	53							
94		99215 63 minutes	63							
95		Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**36.0**	**36.0**	**0.0**	**36.0**	**0.0**
96	CA039		L037D	RN/LPN/MTA	0.37					
99		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37					
102		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFEREN**
2						**CPT Code 22514**		**CPT Code 64628**		**CPT Cod**
3		***RUC Collaboration Website***				Percutaneous vertebral augmentation, including cavity creation (fracture		Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance;		Percutaneou augmer including creation (
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 14 Specialty: NASS, SIS, AAPM, AAPM&R, ASIPP, ISASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**010**	**010**	**010**	**010**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 4,458.06**	**$ 31.39**	**$ -**	**$ 31.26**	**$ 2,352.68**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**170.0**	**72.0**	**0.0**	**72.0**	**60.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**30.0**	**0.0**	**30.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**116.0**	**6.0**	**0.0**	**6.0**	**60.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**36.0**	**36.0**	**0.0**	**36.0**	**0.0**
103		**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
104	**Supply Code**	**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 4,254.93**	**$ 4.05**	**$ -**	**$ 4.05**	**$ 2,260.81**
105										
106	SA046	pack, drapes, laparotomy (chest-abdomen)	11.9745	pack		1				
107	SA048	pack, minimum multi-specialty visit	4.0507	pack		2	1		1	
108	SA054	pack, post-op incision care (suture)	4.6918	pack		1				
109	SA111	Kyphoplasty kit, first fracture	3771.85	kit		1				
110	SB001	cap, surgical	0.9072	item		3				
111	SB008	drape, sterile, c-arm, fluoro	5.161	item		1				
112	SB012	drape, sterile, for Mayo stand	1.2245	item		1				
113	SB024	gloves, sterile	0.8925	pair		2				
114	SB028	gown, surgical, sterile	5.0152	item		2				
115	SB034	mask, surgical, with face shield	3.4	item		3				
116	SC028	needle, 18-26g 1.5-3.5in, spinal	8.2985	item		1				
117	SC029	needle, 18-27g	0.0523	item		1				
118	SF033	scalpel with blade, surgical (#10-20)	0.9535	item		1				
119	SF055	Bone biopsy device	167.6375	item		1				
120	SG056	gauze, sterile 4in x 4in (10 pack uou)	1.0995	item		1				
121	SG074	steri-strip (6 strip uou)	1.434	item		1				
122	SH047	lidocaine 1%-2% inj (Xylocaine)	0.0537	ml		20				
123	SH100	Bone cement with mixer	237.21	item		1				
124	SJ017	DuraPrep surgical soln (26ml uou)	7.9575	item		1				
125	SK075	skin marking pen, sterile (Skin Skribe)	1.477	item		1				
126	SA112	Kyphoplasty kit, additional fracture	2260.8075	kit		0				1
129		**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
130	**Equipment Code**	**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 138.01**	**$ 0.70**	**$ -**	**$ 0.57**	**$ 68.47**
131										
132	EQ168	light, exam	1332.1952		0.003535282	36	36		0	
133	EQ138	instrument pack, medium ($1500 and up)	1500		0.00697135	58	0			30
134	EQ032	IV infusion pump	2425.4345		0.00643644	11	0			
135	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	3434.875		0.011086513	11	0			
136	EL014	room, radiographic-fluoroscopic	600544.445		2.275474402	58	0			30
137	EF031	table, power	5968.4775		0.015838707	36	36		36	
138	EF027	table, instrument, mobile	557.4445		0.001239976	11	0			
139	EF018	stretcher	6550.0158		0.017381951	11	0			
140	ED053	Professional PACS Workstation	15254.9857		0.060443247	32	0			
141	ED050	Technologist PACS workstation	5557		0.022017924	118	0			
144										

	A	B	L	M	N
1	**RUC Practice Expense Spreadsheet**		**CE CODE**	**RECOMMENDED**	
2			**e 22515**	**CPT Code 64629**	
3		***RUC Collaboration Website***		Thermal destruction	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 14** **Specialty: NASS, SIS, AAPM, AAPM&R, ASIPP, ISASS**	s vertebral tation, cavity fracture	of intraosseous basivertebral nerve, inclusive of all imaging guidance;	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	$ -	$ -	$ -
13		**PRE-SERVICE PERIOD**			
14		**Start: Following visit when decision for surgery/procedure made**			
15	CA001	Complete pre-service diagnostic and referral forms			
16	CA002	Coordinate pre-surgery services (including test results)			
17	CA003	Schedule space and equipment in facility			
18	CA004	Provide pre-service education/obtain consent			
19	CA005	Complete pre-procedure phone calls and prescription			
20	CA006	Confirm availability of prior images/studies			
21	CA007	Review patient clinical extant information and questionnaire			
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)			
29		**End: When patient enters office/facility for surgery/procedure**			
30		**SERVICE PERIOD**			
31		**Start: When patient enters office/facility for surgery/procedure:**			
32		**Pre-Service (of service period)**			
33					
34	CA009	Greet patient, provide gowning, ensure appropriate medical records are available			
35	CA010	Obtain vital signs			
36	CA011	Provide education/obtain consent			
37	CA012	Review requisition, assess for special needs			
38	CA013	Prepare room, equipment and supplies			
39	CA014	Confirm order, protocol exam			
40	CA015	Setup scope (nonfacility setting only)			
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient			
42	CA017	Sedate/apply anesthesia			
45		*Other activity: please include short clinical description here and type new in column A*			
48		**Intra-service (of service period)**			
49					
50	CA018	Assist physician or other qualified healthcare professional--directly related to physician work time (67%)			
51	CA018	Assist physician or other qualified healthcare professional--directly related to physician work time (67%)			
52	CA019	Assist physician or other qualified healthcare professional--directly related to physician work time (67%)			
53	CA019	Assist physician or other qualified healthcare professional--directly			
56	CA020	Assist physician or other qualified healthcare professional--directly related to physician work time (other%)			
57	CA020	Assist physician or other qualified healthcare professional--directly			
58	CA021	Perform procedure/service---NOT directly related to physician work time			
59		*Other activity: please include short clinical description here and type new in column A*			
62		**Post-Service (of service period)**			
63		Monitor patient following procedure/service, multitasking 1:4			
64	CA022	Monitor patient following procedure/service, no multitasking			
65	CA023	Clean room/equipment by clinical staff			
66	CA024	Clean scope			
67	CA025	Clean surgical instrument package			
68	CA026	Complete post-procedure diagnostic forms, lab and x-ray requisitions			
69	CA027	Review/read post-procedure x-ray, lab and pathology reports			
70	CA028	Check dressings, catheters, wounds			
71	CA029	Technologist QC's images in PACS, checking for all images, reformats, archive, etc.			
72	CA030	Review examination with interpreting MD/DO			
73	CA031	Scan exam documents into PACS. Complete exam in RIS system to complete images into work queue			
74	CA032	Perform regulatory mandated quality assurance activity (service period)			
75	CA033	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)			
76	CA034	Review home care instructions, coordinate visits/prescriptions			
77	CA035	Discharge day management		n/a	
78	CA036	Discharge day management			
81		*Other activity: please include short clinical description here and type new in column A*			
84		**End: Patient leaves office/facility**			
85		**POST-SERVICE PERIOD**			
86		**Start: Patient leaves office/facility**			
87		Conduct patient communications			
88	CA037	Coordinate post-procedure services			
89	CA038	***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**
90		99211 16 minutes			
91		99212 27 minutes			
92		99213 36 minutes			
93		99214 53 minutes			
94		99215 63 minutes			
95		Post-operative visits (total time)	**0.0**	**0.0**	**0.0**
96	CA039				
99		*Other activity: please include short clinical description here and type new in column A*			
102		**End: with last office visit before end of global period**			

	A	B	L	M	N
1	**RUC Practice Expense Spreadsheet**		**CE CODE**	**RECOMMENDED**	
2			**e 22515**	**CPT Code 64629**	
3		***RUC Collaboration Website***		Thermal destruction	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 14** **Specialty: NASS, SIS, AAPM, AAPM&R, ASIPP, ISASS**	s vertebral tation, cavity fracture	of intraosseous basivertebral nerve, inclusive of all imaging guidance;	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
103		**MEDICAL SUPPLIES**			
104	**Supply Code**	**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**
105					
106	SA046	pack, drapes, laparotomy (chest-abdomen)			
107	SA048	pack, minimum multi-specialty visit			
108	SA054	pack, post-op incision care (suture)			
109	SA111	Kyphoplasty kit, first fracture			
110	SB001	cap, surgical			
111	SB008	drape, sterile, c-arm, fluoro			
112	SB012	drape, sterile, for Mayo stand			
113	SB024	gloves, sterile			
114	SB028	gown, surgical, sterile			
115	SB034	mask, surgical, with face shield			
116	SC028	needle, 18-26g 1.5-3.5in, spinal			
117	SC029	needle, 18-27g			
118	SF033	scalpel with blade, surgical (#10-20)			
119	SF055	Bone biopsy device			
120	SG056	gauze, sterile 4in x 4in (10 pack uou)			
121	SG074	steri-strip (6 strip uou)			
122	SH047	lidocaine 1%-2% inj (Xylocaine)			
123	SH100	Bone cement with mixer			
124	SJ017	DuraPrep surgical soln (26ml uou)			
125	SK075	skin marking pen, sterile (Skin Skribe)			
126	SA112	Kyphoplasty kit, additional fracture			
129		**EQUIPMENT**			
130	**Equipment Code**	**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**
131					
132	EQ168	light, exam			
133	EQ138	instrument pack, medium ($1500 and up)			
134	EQ032	IV infusion pump			
135	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)			
136	EL014	room, radiographic-fluoroscopic			
137	EF031	table, power			
138	EF027	table, instrument, mobile			
139	EF018	stretcher			
140	ED053	Professional PACS Workstation			
141	ED050	Technologist PACS workstation			
144					

AMA/Specialty Society RVS Update Committee (RUC)
Vendor/Company Attestation Statement

This form needs to be completed by an authorized representative of any **Vendor or Company** that makes, markets or distributes a product or device utilized in performing the service being surveyed by the AMA/Specialty Society RVS Update Committee (RUC), as part of its CPT® code survey and valuation process, and which has supplied a list of users of such products or devices in connection with the survey and valuation process.

By submitting to the RUC a list of users of the undersigned's product or device as part of the RUC's CPT® code survey and valuation process, I attest that no employee, affiliate, or agent of the undersigned has contacted, and further covenant that they will not contact, any such user in connection with the survey. I hereby represent and warrant that I have the authority to sign this statement on behalf of the undersigned company and that the information herein is true and accurate. I understand that any false or inaccurate information will render the survey invalid, harming both the undersigned and the physicians who use the product or device.

64628, + 64629
CPT® Codes

Relievant Medsystems, Inc.
Vendor/Company Name

By: Mary Hailey

Mary Hailey
Printed Signature

VP Health Economics & Reimbursement
Title

11.09.2020
Date

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Screen: New Technology/ New Service*

January 2021

Dilation of Aqueous Outflow Canal – Tab 15

CPT codes 66174 and 66175 were identified through the New Technology/New Services List. In January 2020, the specialty societies submitted an action plan and the RUC recommended referral to the CPT Editorial Panel May 2020 meeting to possibly revise the descriptor and add exclusionary parentheticals for CPT 66174. In October 2020, the CPT Editorial Panel added a parenthetical to 66174 to restrict reporting this code in conjunction with CPT code 65820.

66174 ***Transluminal dilation of aqueous outflow canal; without retention of device or stent***
The RUC reviewed the survey results from 72 ophthalmologists and assessed the relativity of CPT codes 66174 and 66175; the RUC determined that the relativity of the 25th percentile survey results should be maintained. The RUC determined that the increment between the 25th percentile work RVU value for CPT code 66174 (work RVU = 10.28) and the survey 25th percentile work RVU value for CPT code 66175 (work RVU = 12.00) would yield an increment between these two codes of 1.72. The specialty society agreed that this increment appropriately represents the value between these two codes (representative of the retention of device or stent). This comparison results in a work RVU recommendation of 8.53 for CPT code 66174 with 173 minutes total time. The RUC recommends 13 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 6 minutes of pre-service scrub/dress/wait time, 20 minutes of intra-service time, 6 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99212 office visit, and 4-99213 office visits.

For additional support, the RUC also reviewed CPT code 66174 by isolating the same-day work and comparing it to other existing 000-day global codes. The RUC selected two 000-day global codes: CPT code 15273 *Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children* (work RVU = 3.50 and 20 minutes intra-service time) and CPT code 16035 *Escharotomy; initial incision* (work RVU = 3.74 and 20 minutes intra-service time). The RUC chose these values because they have intra-service times of 20 minutes (identical to the survey median intra-service time of 20 minutes). The RUC then added the total work RVU value of the 0.5-99238, 4-99213, and 1-99212 outpatient office visits (total work RVU = 5.00) to the selected bracket values. This methodology yields work RVU values of 8.50 for CPT code 15273 and 8.74 for CPT code 16035. This is a strong indication that the 8.53 work RVU recommendation for CPT code 66174 is appropriate when comparing to other services. **The RUC recommends a work RVU of 8.53 for CPT code 66174.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

66175 ***Transluminal dilation of aqueous outflow canal; with retention of device or stent***
The RUC reviewed the survey results from 49 ophthalmologists for CPT code 66175 and determined that it was appropriate to recommend a direct work RVU crosswalk to CPT code 67110 *Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)* (work RVU = 10.25, 30 minutes intra-service time, 196 minutes total time). The RUC recommends 13 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 6 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, 7 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99212 office visit, and 4-99213 office visits.

Additionally, the RUC compared the survey code to CPT code 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation* (work RVU = 10.25, 30 minutes of intra-service time, 175 minutes of total time) and noted that both codes have identical intra-service time and involve similar physician work, supporting the recommended work value of 10.25. **The RUC recommends a work RVU of 10.25 for CPT code 66175.**

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

RUC Database Flag
The RUC recommends to flag CPT code 66174 as "do not use to validate for physician work" since the RUC recommendation was not based on direct survey RVUs.

Practice Expense
For CPT codes 66174 and 66175, the Practice Expense Subcommittee approved the standard 090-day global period direct practice expense inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Eye and Ocular Adnexa **Anterior Segment** **Anterior Sclera** **Excision**				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

▲66174	R1	Transluminal dilation of aqueous outflow canal; without retention of device or stent (Do not report 66174 in conjunction with 65820)	090	8.53
(f) 66175	R2	with retention of device or stent	090	10.25

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66174 Tracking Number R1 Original Specialty Recommended RVU: **8.60**
Presented Recommended RVU: **8.53**
Global Period: 090 Current Work RVU: **12.85** RUC Recommended RVU: **8.53**

CPT Descriptor: Transluminal dilation of aqueous outflow canal; without retention of device or stent

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with a five-year history of chronic open angle glaucoma with intraocular pressure uncontrolled in the right eye. Visual field testing of the right eye reveals progressive glaucomatous damage.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 22% , In the ASC 78%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications. Perform a surgical time out. Administer sub-Tenon, peribulbar, or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface. Position the operating microscope.

Description of Intra-Service Work: Corneal traction sutures are placed. The sclera is exposed through a 6 mm conjunctival incision at the desired surgical site. A limbal-based superficial scleral flap, approximately 4 mm in width and 4 mm in length, is made to a depth of one-third scleral thickness, or approximately 300 microns. A second, inner scleral flap is made directly under the superficial flap, approximately 0.5 mm anterior to the margin of the superficial flap, to a depth approximately 100 microns above the level of the ciliary body.

The inner scleral flap is progressively dissected anteriorly to the aqueous outflow canal (Schlemm canal), exposing Descemet membrane. The membrane is then excised at the anterior limit of the dissection to de-roof the canal and create a window. Both of the exposed ostia of the canal are dilated first with balanced salt solution and then viscoelastic. A paracentesis is performed.

A flexible microcatheter is inserted into the canal and advanced. The catheter is slightly withdrawn and additional viscoelastic injected when areas of resistance are encountered, then further advanced the entire extent of the canal (360 degrees. The microcatheter is then withdrawn while viscoelastic is simultaneously injected, dilating the canal for its entire extent.

Viscoelastic is aspirated from the anterior chamber with an irrigation/aspiration handpiece. The anterior chamber is reformed with balanced salt solution and the intraocular pressure adjusted to a physiologic range. The outer scleral flap and conjunctiva are separately sutured closed to seal the surgical site. The incisions are tested for leaks. The lid speculum is removed. Antibiotic ointment is placed on the eye as necessary. The eye is patched with a soft patch and a rigid shield.

Description of Post-Service Work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow

up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Emily Jones, MD (AAO/AGS)					
Specialty Society(ies):	American Academy of Ophthalmology (AAO)					
CPT Code:	66174					
Sample Size:	1346	**Resp N:**	72			
Description of Sample:	Random sample of US practicing ophthalmologists of AAO and the American Glaucoma Society (AGS).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	5.50	**20.00**	30.00	80.00
Survey RVW:		7.00	10.28	**12.35**	13.56	20.00
Pre-Service Evaluation Time:				**21.00**		
Pre-Service Positioning Time:				**5.00**		
Pre-Service Scrub, Dress, Wait Time:				**8.50**		
Intra-Service Time:		7.00	15.00	**20.00**	30.00	60.00
Immediate Post Service-Time:	**6.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**115.00**	99211x **0.00** 12x **0.00** 13x **5.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	66174	**Recommended Physician Work RVU: 8.53**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**6.00**	**18.00**	**-12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**108.00**	99211x **0.00** 12x **1.00** 13x **4.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66183	090	13.20	**RUC Time**

CPT Descriptor Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66184	090	9.58	**RUC Time**

CPT Descriptor Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54530	090	8.46	**RUC Time**	1,190

CPT Descriptor 1 Orchiectomy, radical, for tumor; inguinal approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 2 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

Other Reference CPT Code	Global	Work RVU	Time Source
67210	090	6.36	**RUC Time**

CPT Descriptor Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 36.1 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 18.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 66174	Top Key Reference CPT Code: 66183	2nd Key Reference CPT Code: **66184**
Median Pre-Service Time	20.00	20.00	25.00
Median Intra-Service Time	20.00	45.00	60.00
Median Immediate Post-service Time	6.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	108.0	163.00	140.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**173.00**	**257.00**	**254.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	8%	58%	31%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	62%	31%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	15%	81%
Physical effort required	8%	46%	46%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and	8%	58%	35%

judgment of physician • Estimated risk of malpractice suit with poor outcome	

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	23%	54%	23%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	31%	62%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	46%	54%
Physical effort required	31%	62%	8%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	31%	54%	15%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66174, *Transluminal dilation of aqueous outflow canal; without retention of device or stent* and CPT 66175, *Transluminal dilation of aqueous outflow canal; with retention of device or stent* are 090-day global CPT codes describing non-penetrating surgical treatments for glaucoma. They were initially published in 2011 and have been reviewed periodically under the new technology screen. Both had very few claims until 2017, at which time CPT 66174 began doubling in volume while CPT 66175 experienced a significant reduction in claims.

The increase in 66174 utilization is because it is a newer glaucoma procedure that doesn't create an external conjunctival bleb, with its attendant long-term risks of scarring, failure, and infection. Therefore, this procedure is being done on some patients that would have had a full-thickness bleb-producing glaucoma procedure and on some patients with glaucoma as an alternative to multiple topical glaucoma medications, particularly when those

patients are undergoing cataract surgery. This also explains the performance of 66174 in conjunction with cataract surgery 60% of the time. The frequent reporting of 66174 with goniotomy, 65820 – 40% of the time – has been a source of concern for some time. It is not warranted because the work of 65820 is already included in 66174. The Academy advocated for a CCI edit to bundle the two procedures, and that went into effect as of July 1, 2020.

CPT 66175, which adds permanent stent placement to the dilation procedure, has dropped off dramatically in claims volume. Permanent stent placement was initially thought to result in greater and possibly longer-lasting pressure reduction, but differences have not proven to be as significant as anticipated, resulting in a shift in volume towards the shorter procedure.

Both codes were surveyed for the January 2021 meeting.

CPT 66174 and 66175 are in a section of CPT labeled "Anterior Sclera – Excision" with six other procedures. CPT 66130, *Excision of lesion, sclera*, is unrelated to any of the other codes in the section, which are all for treatment of glaucoma. The five other glaucoma procedures in the section (CPT 66150, 66155, 66160, 66170, and 66172) are a family of codes that describe various means of creating a fistula with a filtering bleb to reduce intraocular pressure. The surgical technique is markedly different from that of CPT 66174 and 66175, which increase outflow through the trabecular meshwork without creating a fistula or a bleb and do not include excision of sclera. The intraoperative physician work and postoperative management of CPT 66174 and 66175 differ because of the absence of the fistula and bleb, making them in a separate family from CPT 66150-66172.

A survey of CPT 66174 sent to a random sample of American Academy of Ophthalmology and American Glaucoma Society members had 72 respondents, with 97% indicating the vignette to be typical. The code's current work value is 12.85 RVU. The survey median WRVU was 12.35 and the 25th percentile was 10.28. The median IST was 20 minutes. The survey showed five 99213 postoperative visits.

The top key reference service, chosen by 36% of respondents, was CPT 66183, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach*
(RUC 2013), with a WRVU of 13.20, an IST of 45 minutes, and five level 3 and three level 2 postoperative visits. The second reference service, chosen by 18% of respondents, was CPT 66184, *Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft* (RUC 2014), with a WRVU of 9.58, an IST of 60 minutes, and four level 3 and three level 2 postoperative visits. Both have substantially longer ISTs than the surveyed code to create or revise a filtering conjunctival bleb and more postoperative visits to manage the bleb. Most of the intraservice work of the chosen reference codes, while on an open eye, is extraocular. In contrast, the surveyed code involves primarily intraocular work. Fifty-eight percent of respondents ranked the surveyed code as identical to the top reference service on overall intensity and complexity, with 34% ranking the surveyed code higher. The majority ranked the surveyed code (66174) higher than the top reference service on technical skill and were split on physical effort.

The expert panel of the AAO and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel agreed with the median IST of 20 minutes. This is a substantial reduction from the current value of 60 minutes and is related to increasing familiarity with the procedure and significant improvements in the instrumentation used to cannulate the outflow canal since introduction of the procedure.

The panel agreed with the surveyed number of postoperative visits but reduced the level of one of the postoperative visits from 99213 to 99212. The level 2 visit is done on the first postoperative day to check vision, pressure, incision integrity, and level of inflammation. These patients typically have unstable postoperative IOP due to their glaucoma and require frequent pressure monitoring. They also have significant and persistent postoperative inflammation related to intraoperative instrumentation of uveal tissue for 360 degrees, necessitating more frequent dilated examinations to monitor the retina for development of cystoid macular edema (CME). Early detection and treatment of CME, prior to reduced visual acuity, improves visual outcomes but requires a careful dilated exam. Dilated level 3 examinations are typical at 1, 2-3, 6-8, and 10-12 weeks. This duration of inflammation after surgery with the attendant risk of CME was not recognized at the time the

procedure was introduced and valued in 2010. This explains why the number of dilated examinations has increased from 2 to 4 even as the total number of postop visits has decreased from 6 to 5.

We chose pre-service package 1 (straightforward patient, straightforward procedure) and reduced the survey pre-evaluation time from 21 to 13 minutes to match the package. We reduced the survey positioning and scrub/dress/wait times from 5 and 9 minutes to the package times of 1 and 6 minutes respectively. We used the survey post-service time median of 6 minutes, which is less than the 18 minutes of post-service time package 7A (local anesthesia, straightforward procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 173 minutes, with an IST of 20 minutes.

We considered the survey 25th percentile work value of 10.28 and rejected it as too high, based on the significant reduction in IST found in the survey and an associated IWPUT of 0.239, creating an anomalous relationship with other intraocular procedures.

There are very few eligible crosswalks for a short-IST code with multiple postop visits. There are only six 090-day global CPT codes in the RUC database with ISTs between 16 and 24 minutes that have been reviewed in the last 10 years. One has a negative IWPUT and another has been flagged as not to be used to validate physician work. The remainder (CPT 22310, 26055, 26160, and 67914) have work values ranging from 3.11-3.75 RVU, well below the survey low value and any reasonable estimate of necessary physician work for an intraocular glaucoma procedure.

We considered a crosswalk to CPT 67210, *Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation* (RUC 2010), with 6.36 WRVU, an IST of 15 minutes, and a total time of 106 minutes. CPT 66711, *Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens* (RUC 2019) is an even better match, with a 20-minute IST identical to that of the surveyed code and a much closer total time of 191 minutes. In 2019 the RUC recommended a work value of 6.36 RVU for CPT 66711, but this was reduced by CMS to 5.62 RVU. The work value of 6.36 is below the survey low value, and results in an IWPUT of 0.043, low for an intraocular procedure.

After considering reviewer comments and discussion at the pre-facilitation meeting, we also considered two additional incremental methods:

- Reduce our recommended value for CPT 66175, 10.25 WRVU, by the difference in the survey 25th percentile work values for CPT 66175 (12.00) and CPT 66174 (10.28). This results in a work of 8.53 WRVU for 66174. The associated IWPUT of 0.152 remains higher than the procedure's current IWPUT of 0.131.
- An IWPUT-matching method which acknowledges that although the procedure takes less time than when it was introduced, the intensity has not changed. The work value that matches the current IWPUT (0.131) is 8.11 RVU.

We ultimately settled on the latter method and a value of 8.11 WRVU as the most accurate way to value the procedure. This is below the survey 25th percentile value. The IWPUT (0.131) places the procedure in an appropriate intensity rank order with other intraocular procedures.

We recommend a work value of 8.11 WRVU for CPT 66174, with times of 20/20/6 and a total time of 173 minutes. Because of the non-traditional valuation methodology, we also recommend that CPT 66174 be flagged to not be used to validate physician work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) It is one option for patients with concurrent cataract and poorly controlled glaucoma.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3. CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period	% Billed Together
4. 66984	20	20	5	126	7.35	090	60.6%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Esimate based on RUC DB and recent growth.

Specialty Ophthalmology Frequency 30000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on RUC DB and recent growth.

Specialty Ophthalmology Frequency 15000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 66174

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66175 Tracking Number R2 Original Specialty Recommended RVU: **10.25**
Presented Recommended RVU: **10.25**
Global Period: 090 Current Work RVU: **13.60** RUC Recommended RVU: **10.25**

CPT Descriptor: Transluminal dilation of aqueous outflow canal; with retention of device or stent

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male presents with a five-year history of chronic open angle glaucoma with intraocular pressure uncontrolled in the right eye. Visual field testing of the right eye reveals progressive glaucomatous damage.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 22% , In the ASC 78%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications. Perform a surgical time out. Administer sub-Tenon, peribulbar, or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface. Position the operating microscope.

Description of Intra-Service Work: Corneal traction sutures are placed. The sclera is exposed through a 6 mm conjunctival incision at the desired surgical site. A limbal-based superficial scleral flap, approximately 4 mm in width and 4 mm in length, is made to a depth of one-third scleral thickness, or approximately 300 microns. A second, inner scleral flap is made directly under the superficial flap, approximately 0.5 mm anterior to the margin of the superficial flap, to a depth approximately 100 microns above the level of the ciliary body.

The inner scleral flap is progressively dissected anteriorly to the aqueous outflow canal (Schlemm canal), exposing Descemet membrane. The membrane is then excised at the anterior limit of the dissection to de-roof the canal and create a window. Both of the exposed ostia of the canal are dilated first with balanced salt solution and then viscoelastic. A paracentesis is performed.

A flexible microcatheter is inserted into the canal and advanced. The catheter is slightly withdrawn and additional viscoelastic injected when areas of resistance are encountered, then further advanced the entire extent of the canal (360 degrees. With the microcatheter in place, a device (e.g., flexible stent, suture) is attached to the distal tip of the microcatheter. The microcatheter is then withdrawn while viscoelastic is simultaneously injected, dilating the canal and facilitating maintenance of the stent within the canal for its entire extent (360 degrees). Once the flexible microcatheter is removed, the stent remaining within the canal is tied at a tension which will facilitate aqueous flow through the trabecular meshwork.

Viscoelastic is aspirated from the anterior chamber with an irrigation/aspiration handpiece. The anterior chamber is reformed with balanced salt solution and the intraocular pressure adjusted to a physiologic range. The outer scleral flap and conjunctiva are separately sutured closed to seal the surgical site and cover the stent. The incisions are tested for leaks. The lid speculum is removed. Antibiotic ointment is placed on the eye as necessary. The eye is patched with a soft patch and a rigid shield.

Description of Post-Service Work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Emily Jones, MD (AAO/AGS)					
Specialty Society(ies):	American Academy of Ophthalmology (AAO)					
CPT Code:	66175					
Sample Size:	1346	**Resp N:**	49			
Description of Sample:	Random sample of US practicing ophthalmologists of AAO and the American Glaucoma Society (AGS)					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**3.50**	11.00	75.00
Survey RVW:		7.00	12.00	**13.50**	14.00	22.00
Pre-Service Evaluation Time:				**21.00**		
Pre-Service Positioning Time:				**5.00**		
Pre-Service Scrub, Dress, Wait Time:				**6.00**		
Intra-Service Time:		12.00	20.00	**30.00**	45.00	60.00
Immediate Post Service-Time:	**7.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**115.00**	99211x **0.00** 12x **0.00** 13x **5.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	66175	**Recommended Physician Work RVU: 10.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**7.00**	**18.00**	**-11.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**108.00**	99211x **0.00** 12x **1.00** 13x **4.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66183	090	13.20	**RUC Time**

CPT Descriptor Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66179	090	14.00	**RUC Time**

CPT Descriptor Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54437	090	11.50	**RUC Time**	54

CPT Descriptor 1 Repair of traumatic corporeal tear(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
50590	090	9.77	**RUC Time**	54,658

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

Other Reference CPT Code	Global	Work RVU	Time Source
67110	090	10.25	**RUC Time**

CPT Descriptor Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 32.6 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 28.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 66175	Top Key Reference CPT Code: 66183	2nd Key Reference CPT Code: **66179**
Median Pre-Service Time	20.00	20.00	25.00
Median Intra-Service Time	30.00	45.00	55.00
Median Immediate Post-service Time	7.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	108.0	163.00	163.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**184.00**	**257.00**	**272.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	6%	56%	38%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	50%	38%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	19%	81%
Physical effort required	6%	31%	63%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and	6%	44%	50%

judgment of physician • Estimated risk of malpractice suit with poor outcome	

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	50%	29%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	64%	36%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	14%	79%
Physical effort required	15%	54%	31%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	71%	29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66174, *Transluminal dilation of aqueous outflow canal; without retention of device or stent* and CPT 66175, *Transluminal dilation of aqueous outflow canal; with retention of device or stent* are 090-day global CPT codes describing non-penetrating surgical treatments for glaucoma. They were initially published in 2011 and have been reviewed periodically under the new technology screen. Both had very few claims until 2017, at which time CPT 66174 began doubling in volume while CPT 66175 experienced a significant reduction in claims. This is discussed in detail in the SOR for CPT 66174.

As noted in the SOR for CPT 66174, both of these codes are in a family by themselves within the CPT section "Anterior Sclera – Excision" but do not actually describe a scleral excision procedure.

A survey of CPT 66175 sent to a random sample of American Academy of Ophthalmology and American Glaucoma Society members had 49 respondents, with 84% indicating the vignette to be typical. The code's current work value is 13.60 RVU. The survey median WRVU was 13.50 and the 25th percentile was 12.00. The median IST was 30 minutes. The survey showed five 99213 postoperative visits.

The top key reference service, chosen by 33% of respondents, was CPT 66183, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (RUC 2013), with a WRVU of 13.20, an IST of 45 minutes, and five level 3 and three level 2 postoperative visits. The second reference service, chosen by 29% of respondents, was CPT 66179, *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (RUC 2014), with a WRVU of 14.00, an IST of 55 minutes, and five level 3 and three level 2 postoperative visits. Both have substantially longer ISTs than the surveyed code related to the number of postoperative visits necessary to manage a filtering bleb. Most of the intraservice work of the chosen reference codes, while on an open eye, is extraocular. In contrast, the surveyed code involves primarily intraocular work, increasing its complexity. The majority of respondents ranked the surveyed code as identical to both reference services on overall intensity and complexity and mental effort and judgment. The majority ranked the survey code higher than the top reference service on technical skill and physical effort and were split on overall psychological stress.

The expert panel of the AAO and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel agreed with the median IST of 30 minutes. This is less than half the current value of 68 minutes and is related to increasing familiarity with the procedure and improvements in the instrumentation, the surgical approach, and the stent used to cannulate the outflow canal since introduction of the procedure.

The panel agreed with the surveyed number of postoperative visits but reduced the level of one of the postoperative visits from 99213 to 99212. The level 2 visit is done on the first postoperative day to check vision, pressure, incision integrity, and level of inflammation. These patients typically have unstable postoperative IOP due to their glaucoma and require frequent pressure monitoring. They also have significant and persistent postoperative inflammation related to intraoperative instrumentation of uveal tissue for 360 degrees, necessitating more frequent dilated examinations to monitor for development of cystoid macular edema. This is discussed in detail in the SOR for CPT 66174. Dilated level 3 examinations are typical at 1, 2-3, 6-8, and 10-12 weeks postoperatively.

We chose pre-service package 1 (straightforward patient, straightforward procedure) and reduced the survey pre-evaluation time from 21 to 13 minutes to match the package. We reduced the survey positioning time from 5 minutes to the package time of 1 minute and maintained the survey scrub/dress/wait time of 6 minutes, matching the package time. We used the survey post-service time median of 7 minutes, which is less than the 18 minutes of post-service time package 7A (local anesthesia, straightforward procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 184 minutes, with an IST of 30 minutes.

There are only six 090-day global CPT codes in the RUC database with ISTs between 26 and 34 minutes that have been reviewed within 10 years. Most have much shorter total times and fewer postoperative visits than the surveyed code and work values below the survey's low value. The procedure with the closest work value to the survey's 25th percentile is CPT 66982, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation* (RUC 2019) with 10.25 WRVU, an identical IST of 30 minutes and an almost identical IST of 175 minutes, 2 minutes shorter than that of the surveyed code.

We recommend a work value of 10.25 RVU for CPT 66175, with a crosswalk to CPT 66982, complex cataract surgery. The times are an excellent match. The IWPUT at this value, 0.158, is appropriately lower than that of complex cataract surgery (0.180) and is consistent with the intensity and complexity of a procedure on a patient with poorly controlled glaucoma requiring a high degree of technical skill cannulating Schlemm canal for 360

degrees without unroofing the trabecular meshwork. The IWPUT is similar to that of vitrectomy codes CPT 67042 and 67041 (0.160), placing CPT 66175 in appropriate rank order with other intraocular procedures. The recommended work value is below the survey 25th percentile of 12.00 WRVU and well below the current value of 13.60 WRVU.

We are aware that the work value of CPT 66982 is being reaffirmed at this meeting. Although it was reviewed in 2019, it is in a family with a new CPT code, 669X1, which has been surveyed for this meeting. If CPT 66982 is considered ineligible as a crosswalk due to this status, we will substitute as a crosswalk the same procedure that was used as a crosswalk to value CPT 66982 in 2019. That procedure is CPT 67110, *Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)* (RUC 2014), with 10.25 WRVU, an identical 30-minute IST, and a total time of 196 minutes. CPT 67110 involves intraocular gas injection. Although a complex intraocular procedure, it does not involve the sustained intraocular manipulations of either CPT 66982 or 66175 or the vitrectomy codes noted above (CPT 67041, 67042). CPT 67110 therefore appropriately has a lower IWPUT than the vitrectomy or cataract procedures and the surveyed code, CPT 66175, maintaining an appropriate rank order of complexity among intraocular procedures.

We recommend a work value of 10.25 WRVU for CPT 66175, with times of 20/30/7 and a total time of 184 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 400
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on RUC DB and recent growth.

Specialty Ophthalmology Frequency 400 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on RUC DB and recent growth.

Specialty Ophthalmology Frequency 200 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 66175

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

ISSUE: Dilation of Aqueous Outflow Canal (66174, 66175)

TAB: 15

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	66183	90	Insertion of ar	26	0.126	0.051			13.20			257	10	5	5			45			10						0.5				5	3					
2nd REF	66184	90	Revision of ac	13	0.048	0.038			9.58			254	19	1	5			60			10						0.5				4	3					
CURRENT	66174	90	Transluminal dilatio		0.131	0.060			12.85			215	10	1	5			60			10						0.5				2	4					
SVY	66174	90	Transluminal	72	0.336	0.070	7.00	10.28	12.35	13.56	20.00	176	21	5	8.5	7	15	20	30	60	6								5					0	6	20	30	80
REC	66174	90	Transluminal dilatio		0.152	0.049			8.53			173	13	1	6			20			6						0.5				4	1					

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	66183	90	Insertion of ar	16	0.126	0.051			13.20			257	10	5	5			45			10						0.5				5	3					
2nd REF	66179	90	Aqueous shur	14	0.116	0.051			14.00			272	19	1	5			55			10						0.5				5	3					
CURRENT	66175	90	Transluminal dilatio		0.127	0.061			13.60			223	10	1	5			68			10						0.5				2	4					
SVY	66175	90	Transluminal	49	0.262	0.073	7.00	12.00	13.50	14.00	22.00	184	21	5	6	12	20	30	45	60	7								5					0	0	4	11	75
XWALK	67110	90	Repair of retinal det		0.129	0.052			10.25			196	12	1	5			30			10								6									
REC	66175	90	Transluminal dilatio		0.158	0.056			10.25			184	13	1	6			30			7						0.5				4	1					

FACILITY DIRECT PE INPUTS **CPT CODE(S):_66174___**
SPECIALTY SOCIETY(IES):__AAO_____
PRESENTER(S):_Ankoor Shah, David Glasser, and Emily Jones__

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
66174	A 55-year-old male presents with a five-year history of chronic open angle glaucoma with intraocular pressure uncontrolled in the right eye. Visual field testing of the right eye reveals progressive glaucomatous damage.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. The consensus committee considered the survey data and PE details to determine clinical time. Additionally, applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Reference Code is the Existing Code

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Transluminal dilation of aqueous outflow canal surgery is major glaucoma surgery with a 90-day global. Standard inputs are used during the pre-service period consistent with PEAC recommendations for 90-day global procedures.

   b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

   c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam. Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used. Screening lane: Standard office visit formula used.

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):_66175___**
SPECIALTY SOCIETY(IES):__AAO_____
PRESENTER(S):_Ankoor Shah, David Glasser, and Emily Jones __

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
66175	A 55-year-old male presents with a five-year history of chronic open angle glaucoma with intraocular pressure uncontrolled in the right eye. Visual field testing of the right eye reveals progressive glaucomatous damage.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. The consensus committee considered the survey data and PE details to determine clinical time. Additionally, applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Reference Code is the Existing Code

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Transluminal dilation of aqueous outflow canal surgery is major glaucoma surgery with a 90-day global. Standard inputs are used during the pre-service period consistent with PEAC recommendations for 90-day global procedures.

   b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

   c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam. Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used. Screening lane: Standard office visit formula used.

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURI**
2						**66174**		**66174**		**66**
3		***RUC Collaboration Website***				Transluminal dilation of aqueous outflow canal; without retention of device or stent		Transluminal dilation of aqueous outflow canal; without retention of device or stent		Translumi of aqueo canal; wit of device
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 15 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**					**090**		**090**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 136.76**	**$ -**	**$ 127.83**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**246.0**	**0.0**	**237.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**180.0**	**0.0**	**171.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 93.48**	**$ -**	**$ 90.06**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**	L038A							
15	CA001	Complete pre-service diagnostic and referral forms	L038A	COMT/COT/RN/CS	0.38		5		5	
16	CA002	Coordinate pre-surgery services (including test results)	L038A	COMT/COT/RN/CS	0.38		20		20	
17	CA003	Schedule space and equipment in facility	L038A	COMT/COT/RN/CS	0.38		8		8	
18	CA004	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CS	0.38		20		20	
19	CA005	Complete pre-procedure phone calls and prescription	L038A	COMT/COT/RN/CS	0.38		7		7	
20	CA006	Confirm availability of prior images/studies	L038A	COMT/COT/RN/CS	0.38					
21	CA007	Review patient clinical extant information and questionnaire	L038A	COMT/COT/RN/CS	0.38					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L038A	COMT/COT/RN/CS	0.38					
23			L038A	COMT/COT/RN/CS	0.38					
26		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L038A	COMT/COT/RN/CS	0.38					
34	CA010	Obtain vital signs	L038A	COMT/COT/RN/CS	0.38					
35	CA011	Provide education/obtain consent	L038A	COMT/COT/RN/CS	0.38					
36	CA012	Review requisition, assess for special needs	L038A	COMT/COT/RN/CS	0.38					
37	CA013	Prepare room, equipment and supplies	L038A	COMT/COT/RN/CS	0.38					
38	CA014	Confirm order, protocol exam	L038A	COMT/COT/RN/CS	0.38					
39	CA015	Setup scope (nonfacility setting only)	L038A	COMT/COT/RN/CS	0.38					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COT/RN/CS	0.38					
41	CA017	Sedate/apply anesthesia	L038A	COMT/COT/RN/CS	0.38					
42			L038A	COMT/COT/RN/CS	0.38					
45		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
48		**Intra-service (of service period)**								
49	CA018	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
50	CA019	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
51	CA020	Assist physician or other qualified healthcare professional---directly	L038A	COMT/COT/RN/CS	0.38					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L038A	COMT/COT/RN/CS	0.38					
55			L038A	COMT/COT/RN/CS	0.38					
56		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L038A	COMT/COT/RN/CS	0.38					
61	CA023	Monitor patient following procedure/service, no multitasking	L038A	COMT/COT/RN/CS	0.38					
62	CA024	Clean room/equipment by clinical staff	L038A	COMT/COT/RN/CS	0.38					
63	CA025	Clean scope	L038A	COMT/COT/RN/CS	0.38					
64	CA026	Clean surgical instrument package	L038A	COMT/COT/RN/CS	0.38					
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L038A	COMT/COT/RN/CS	0.38					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L038A	COMT/COT/RN/CS	0.38					
67	CA029	Check dressings, catheters, wounds	L038A	COMT/COT/RN/CS	0.38					
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L038A	COMT/COT/RN/CS	0.38					
69	CA031	Review examination with interpreting MD/DO	L038A	COMT/COT/RN/CS	0.38					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L038A	COMT/COT/RN/CS	0.38					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L038A	COMT/COT/RN/CS	0.38					
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L038A	COMT/COT/RN/CS	0.38					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L038A	COMT/COT/RN/CS	0.38					
74	CA036	Discharge day management	L038A	COMT/COT/RN/CS	0.38	**n/a**	6	**n/a**	6	**n/a**
75			L038A	COMT/COT/RN/CS	0.38					
78		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L038A	COMT/COT/RN/CS	0.38					
85	CA038	Coordinate post-procedure services	L038A	COMT/COT/RN/CS	0.38					
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27				4		1	
89		99213 36 minutes	36				2		4	
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L038A	COMT/COT/RN/CS	0.38	**0.0**	**180.0**	**0.0**	**171.0**	**0.0**
93			L038A	COMT/COT/RN/CS	0.38					
96		*Other activity: please include short clinical description here and type*	L038A	COMT/COT/RN/CS	0.38					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURI**
2						**66174**		**66174**		**66**
3		***RUC Collaboration Website***				Transluminal dilation of aqueous outflow canal; without retention of device or stent		Transluminal dilation of aqueous outflow canal; without retention of device or stent		Translumi of aqueo canal; wit of device
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 15 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**					**090**		**090**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 136.76**	**$ -**	**$ 127.83**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**246.0**	**0.0**	**237.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**180.0**	**0.0**	**171.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 20.59**	**$ -**	**$ 16.06**	**$ -**
102	SA082	pack, ophthalmology visit (w-dilation)	3.4318	pack			6		4	
103	SA050	pack, ophthalmology visit (no dilation)	2.3363	pack					1	
104										
105										
106										
107										
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ 22.69**	**$ -**	**$ 21.71**	**$ -**
112	EL005	lane, exam (oph)	40526.8425		0.127283043		72		144.0	
113	EL006	lane, screening (oph)	39874.4787		0.125234158		108		27	
114										
115										
116										
117										
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	L	M	N
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**	
2			**175**	**66175**	
3		***RUC Collaboration Website***	nal dilation	Transluminal dilation	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAO**	us outflow n retention e or stent	of aqueous outflow canal; with retention of device or stent	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 136.76**	**$ -**	**$ 127.83**
8		**TOTAL CLINICAL STAFF TIME**	**246.0**	**0.0**	**237.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**180.0**	**0.0**	**171.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 93.48**	**$ -**	**$ 90.06**
13		**PRE-SERVICE PERIOD**			
14		**Start: Following visit when decision for surgery/procedure made**			
15	CA001	Complete pre-service diagnostic and referral forms	5		5
16	CA002	Coordinate pre-surgery services (including test results)	20		20
17	CA003	Schedule space and equipment in facility	8		8
18	CA004	Provide pre-service education/obtain consent	20		20
19	CA005	Complete pre-procedure phone calls and prescription	7		7
20	CA006	Confirm availability of prior images/studies			
21	CA007	Review patient clinical extant information and questionnaire			
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)			
23					
26		*Other activity: please include short clinical description here and type*			
29		**End: When patient enters office/facility for surgery/procedure**			
30		**SERVICE PERIOD**			
31		**Start: When patient enters office/facility for surgery/procedure:**			
32		**Pre-Service (of service period)**			
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are			
34	CA010	Obtain vital signs			
35	CA011	Provide education/obtain consent			
36	CA012	Review requisition, assess for special needs			
37	CA013	Prepare room, equipment and supplies			
38	CA014	Confirm order, protocol exam			
39	CA015	Setup scope (nonfacility setting only)			
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient			
41	CA017	Sedate/apply anesthesia			
42					
45		*Other activity: please include short clinical description here and type*			
48		**Intra-service (of service period)**			
49	CA018	Assist physician or other qualified healthcare professional---directly			
50	CA019	Assist physician or other qualified healthcare professional---directly			
51	CA020	Assist physician or other qualified healthcare professional---directly			
52	CA021	Perform procedure/service---NOT directly related to physician work time			
55					
56		*Other activity: please include short clinical description here and type*			
59		**Post-Service (of service period)**			
60	CA022	Monitor patient following procedure/service, multitasking 1:4			
61	CA023	Monitor patient following procedure/service, no multitasking			
62	CA024	Clean room/equipment by clinical staff			
63	CA025	Clean scope			
64	CA026	Clean surgical instrument package			
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions			
66	CA028	Review/read post-procedure x-ray, lab and pathology reports			
67	CA029	Check dressings, catheters, wounds			
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,			
69	CA031	Review examination with interpreting MD/DO			
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to			
71	CA033	Perform regulatory mandated quality assurance activity (service period)			
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry			
73	CA035	Review home care instructions, coordinate visits/prescriptions			
74	CA036	Discharge day management	6	**n/a**	6
75					
78		*Other activity: please include short clinical description here and type*			
81		**End: Patient leaves office/facility**			
82		**POST-SERVICE PERIOD**			
83		**Start: Patient leaves office/facility**			
84	CA037	Conduct patient communications			
85	CA038	Coordinate post-procedure services			
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**
87		99211 16 minutes			
88		99212 27 minutes	4		1
89		99213 36 minutes	2		4
90		99214 53 minutes			
91		99215 63 minutes			
92	CA039	Post-operative visits (total time)	**180.0**	**0.0**	**171.0**
93					
96		*Other activity: please include short clinical description here and type*			
99		**End: with last office visit before end of global period**			

	A	B	L	M	N
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**	
2			**175**	**66175**	
3		***RUC Collaboration Website***	nal dilation	Transluminal dilation	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAO**	us outflow n retention e or stent	of aqueous outflow canal; with retention of device or stent	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 136.76**	**$ -**	**$ 127.83**
8		**TOTAL CLINICAL STAFF TIME**	**246.0**	**0.0**	**237.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**180.0**	**0.0**	**171.0**
100	**Supply Code**	**MEDICAL SUPPLIES**			
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 20.59**	**$ -**	**$ 16.06**
102	SA082	pack, ophthalmology visit (w-dilation)	6		4
103	SA050	pack, ophthalmology visit (no dilation)			1
104					
105					
106					
107					
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*			
110	**Equipment Code**	**EQUIPMENT**			
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 22.69**	**$ -**	**$ 21.71**
112	EL005	lane, exam (oph)	72		144.0
113	EL006	lane, screening (oph)	108		27
114					
115					
116					
117					
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*			

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Category III Codes

January 2021

Cataract Removal with Drainage Device Insertion – Tab 16

The RUC identified CPT code 0191T via the Category III codes with High Utilization screen (2018 estimated Medicare utilization over 1,000). In January 2020, the RUC recommended that the specialty societies develop a coding application for Category I status. In October 2020, the CPT Editorial Panel replaced two Category III codes with two new codes to report extracapsular cataract removal with insertion of intraocular lens prosthesis and one Category III code to report insertion of anterior segment aqueous drainage device without concomitant cataract removal.

66989 ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more***
The RUC reviewed the survey results from 113 ophthalmologists and cataract and refractive surgeons for CPT code 66989 and determined that the survey 25th percentile work RVU of 12.13 appropriately accounts for the work required to perform this service. The RUC recommends 26 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 7 minutes of pre-service scrub/dress/wait time, 28 minutes of intra-service time, 8 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99212 office visit, and 3-99213 office visit.

The RUC notes that the recommended intra-service time of 28 minutes of intra-service time for CPT code 66989 two minutes less the intra-service time of 30 minutes associated with CPT code 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation*, while the intra-service time for CPT code 66991 is 5 minutes higher than the 20 minutes of intra-service time associated with code CPT 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation*. The RUC noted that this should not be the case, as the insertion of the intraocular lens prosthesis should take the same amount of time and be represented by the same relative work for both procedures. The RUC further noted that it is counterintuitive that 66989's intra-service time would be lower than 66982's intra-service time, as 66989 includes both complex cataract surgery and the insertion of the intraocular anterior segment aqueous drainage device. The specialty society explained that this is likely because the early adopters of this new technology service are highly skilled surgeons who perform these procedures quickly; as this

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

procedure diffuses into the wider population of ophthalmologic surgeons over the next few years, the intra-service time will likely rise above the intra-service time associated with codes 66982 and 66984 and will come in line for both CPT 66989 and 66991.

The RUC compared CPT code 66989 to key reference services CPT code 66183 *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (work RVU = 13.20, total time 257 minutes) and CPT code 66179 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (work RVU = 14.00, total time 272 minutes) and determined that the difference between the survey 25th percentile work RVU value for 66989 and the work RVU value for 66982 appropriately represent the work associated with code 66989 and that this places 66989 in appropriate rank order with the two key reference services, both of which have higher total time and more intense physician work. **The RUC recommends a work RVU of 12.13 for CPT code 66989.**

66991 ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more***
The RUC reviewed the survey results from 114 ophthalmologists and cataract and refractive surgeons for CPT code 66991 and assessed the relativity of CPT code 66991 and CPT code 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation*. The RUC agreed with the specialty society that the difference in work between CPT code 66989 and CPT code 66991 is whether the cataract procedure is complex (CPT code 66989) or routine (CPT code 66991). Therefore, the RUC determined that it would be appropriate to use the increment between the 25th percentile work RVU value for CPT code 66989 and the current RUC-reviewed work RVU value for CPT code 66982 to build a work RVU recommendation for CPT code 66991. The RUC determined that the increment between the 25th percentile work RVU value for CPT code 66989 (work RVU = 12.13) and the current RUC-reviewed work RVU value for CPT code 66982 (work RVU = 10.25) would yield an increment between those two codes of 1.88. This comparison results in a work RVU recommendation of 9.23 for CPT code 66991. The RUC recommends 25 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 7 minutes of pre-service scrub/dress/wait time, 25 minutes of intra-service time, 8 minutes of immediate post-service time, 0.5-99238 discharge visit, 1-99212 office visit, 3-99213 office visit. **The RUC recommends a work RVU of 9.23 for CPT code 66991.**

Affirmation of RUC Recommendations
The RUC reviewed the specialty society's request to affirm the recent valuations for CPT codes 66982, 66984, 66987 and 66988. The specialty society noted that these codes are in the same family as CPT codes 66989 and 66991 but did not need to be resurveyed for the January 2021 RUC meeting as they had just been reviewed at the January 2019 RUC meeting and that there have been no changes in the typical physician work, patient population, technology, and site of service associated with these procedures. The RUC noted that it would be necessary to re-survey this entire family of codes in two years once the new procedures described by CPT codes 66989 and 66991 have diffused into the wider ophthalmology population. **The RUC recommends affirming the current work RVU of 10.25 for code 66982, 7.35 for code 66984, 13.15 for code 66987, and 10.25 for code 66988**.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

RUC Database Flag
The RUC recommends flagging CPT code 66991 as "do not use to validate for physician work" since the RUC used an incremental work RVU building block methodology for valuation.

Practice Expense
For CPT codes 66989 and 66991, the Practice Expense Subcommittee approved the standard 090-day global period direct practice expense inputs. For CPT codes 66982, 66984, 66987, and 66988, the Practice Expense Subcommittee affirmed the current direct practice expense inputs. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

New Technology
CPT codes 66989 and 66991 will be placed on the New Technology list and be re-reviewed by the RUC in two years (with CPT codes 66982, 66984, 66987, and 66988) to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Eye and Ocular Adnexa **Anterior Segment** **Intraocular Lens Procedures**				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(f)66982	S1	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation (For complex extracapsular cataract removal with concomitant endoscopic cyclophotocoagulation, use 66987) (For complex extracapsular cataract removal with concomitant intraocular aqueous drainage device by internal approach, use 66989) (For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)	090	10.25 (No Change) (Affirmed January 2019 RUC Recommendation)
●66989	S2	with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more (For complex extracapsular cataract removal without concomitant aqueous drainage device, use 66982) (For insertion of intraocular anterior segment drainage device into the trabecular meshwork without concomitant cataract removal and intraocular lens implant, use 0671T)	090	12.13
(f)66987	S3	with endoscopic cyclophotocoagulation (For complex extracapsular cataract removal without endoscopic cyclophotocoagulation, use 66982) (For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)	090	13.15 (Affirmed January 2019 RUC Recommendation)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(f)66984	S4	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation (For extracapsular cataract removal with concomitant intraocular aqueous drainage device by internal approach, use 66989) (For insertion of intraocular anterior segment drainage device into the trabecular meshwork without concomitant cataract removal and intraocular lens implant, use 0671T)	090	7.35 (No Change) (Affirmed January 2019 RUC Recommendation)
(f)66988	S5	with endoscopic cyclophotocoagulation (For extracapsular cataract removal without endoscopic cyclophotocoagulation, use 66984) (For complex extracapsular cataract removal with endoscopic cyclophotocoagulation, use 66987) (For insertion of ocular telescope prosthesis, including removal of crystalline lens, use 0308T)	090	10.25 (Affirmed January 2019 RUC Recommendation)
●66991	S6	with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more (For extracapsular cataract removal with intraocular lens implant without concomitant aqueous drainage device, use 66984) (For insertion of intraocular anterior segment drainage device into the trabecular meshwork without concomitant cataract removal with intraocular lens implant, use 0671T)	090	9.23

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Category III Codes				
~~0191T~~	-	~~Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion~~ (0191T has been deleted) (To report anterior segment drainage device implantation without concomitant cataract removal, use 0671T)	~~XXX~~	N/A
~~+0376T~~	-	~~each additional device insertion (List separately in addition to code for primary procedure)~~ ~~(Use 0376T in conjunction with 0191T)~~ (0376T has been deleted) (To report insertion of anterior segment aqueous drainage device without extraocular reservoir, internal approach, see 66989, 66991, 0671T)	~~XXX~~	N/A
●0671T	-	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more (Do not report 0671T in conjunction with 66989, 66991) (For complex extracapsular cataract removal with intraocular lens implant without aqueous drainage device, use 66982) (For extracapsular cataract removal with intraocular lens implant without aqueous drainage device, use 66984) For insertion of anterior segment drainage device into the subconjunctival space, use 0449T)	090	Contractor Priced

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

0449T	*Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device*
+0450T	*each additional device insertion (List separately in addition to code for primary procedure)*
	(Use 0450T in conjunction with 0449T)
	(For insertion of anterior segment drainage device into the trabecular meshwork, use 0671T)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMERICAN ACADEMY
OF OPHTHALMOLOGY

20 F Street NW
Suite 400
Washington, DC
20001-6701

P.O. Box 7424
San Francisco, CA
94120-7424

T: +1 202.737.6662
aao.org

November 5, 2020

Peter Smith, MD
Chair, Specialty Society Relative Value Scale Update Committee
American Medical Association Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Dear Dr. Smith:

The American Academy of Ophthalmology is requesting that the RUC reaffirm the recent valuations for CPT codes 66982, 66984, 66987, and 66988. These procedures are in a family with two new codes, CPT 66989 and 66991, that are being presented at this meeting. The entire family of existing cataract codes was reviewed at the January 2019 RUC meeting. These codes do not need to be re-reviewed at this time because there have been no changes in the procedures: the typical physician work, patient population, technology, and site of service have not changed in many years, and certainly not since the last RUC valuation two years ago.

Additionally, although CPT 66987 and 66988 were new CPT codes in 2020, they are not new technology. These two codes are combinations of long-existing procedures - endocyclophotocoagulation (CPT 66711) plus cataract (CPT 66982 or 66984). They were created because CPT 66711 was being reported over 75% of the time with one of the cataract services.

As such, we will not be surveying nor recommending new values for CPT 66982, 66984, 66987, or 66988 at the January 2021 RUC meeting.

We are happy to discuss this further should you need additional information.

Sincerely,

David B. Glasser, M.D.
AAO RUC Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66989 Tracking Number S2 Original Specialty Recommended RVU: **12.13**
Presented Recommended RVU: **12.13**
Global Period: 090 Current Work RVU: **N/A** RUC Recommended RVU: **12.13**

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old man with a cortical cataract severe enough to no longer allow vision for reading who requires cataract removal and replacement with an intraocular lens. He has a history of use of systemic medications causing floppy iris syndrome and the intraoperative use of an iris retraction device is planned. In addition, his increased intraocular pressure is not well controlled on two topical medications so placement of an aqueous drainage device through an internal approach is planned at the same time.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 16% , In the ASC 82%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications and pupillary dilation. Perform a surgical time out. Administer sub-Tenon or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface..

Description of Intra-Service Work: Insert a lid speculum. Position the microscope. Make a side-port incision 45 to 90 degrees away from the intended site of the surgical incision. Fill the anterior chamber with a viscoelastic. Create a temporal multiplanar limbal/corneal incision into the anterior chamber. Make four additional 1-mm incisions at the limbus in order to place iris hooks in a diamond pattern around the eye. One by one, insert the iris hooks into the incisions and manipulate to retract the iris. Reposition the iris hooks in the areas of loose zonules to better support the iris and the capsule during subsequent steps of cataract removal.

Enter the eye through the main incision with a sharp bent needle to open the anterior capsule, followed by forceps to fashion a circular opening in the anterior capsule of the cataract. Insert a cannula into the eye to perform hydrodissection by injecting balanced salt solution between the lens cortex and capsule, loosening the nuclear and cortical layers of the lens in the process, while maintaining the integrity of the capsule. Hydrodelineate as needed by injecting balanced salt solution between the lens cortex and nucleus. Inject additional viscoelastic into the anterior chamber of the eye prior to phacoemulsification. Check the function of the phacoemulsification handpiece and the machine settings. Remove bubbles by tapping the handpiece with irrigation on. Insert the phacoemulsification tip into the eye and a second instrument through the side port incision.

Using both hands as well as the foot actuated phaco pedal, carefully perform phacoemulsification with simultaneous aspiration of the lens nuclear material. Rotate and dis-assemble the lens to avoid inadvertent trauma to the cornea, lens capsule or iris. Add viscoelastic as needed to maintain a safe working space. Remove the phacoemulsification tip and the second instrument from the eye once all of the nuclear material has been removed. Introduce an irrigation and aspiration tip into the eye to aspirate the remainder of the cortical lens material. Then carefully vacuum and polish the interior surface of the thin lens capsule in an attempt to avoid future secondary membrane formation.

Assess the integrity of the capsule and zonules and determine how much additional support the capsular bag and intraocular lens (IOL) will require. Enlarge incisions and create scleral flaps as needed for the IOL and support system chosen. Insert and suture a capsular tension ring or segment as needed. While maintaining traction on the eye via the side port incision, insert the tip of the IOL injection device into the main incision and place the IOL in the eye. Once in the eye, allow the IOL to unfold without damage to the cornea. Properly position and center the IOL using a lens hook. Suture the IOL and/or capsular bag/zonular complex as needed. Remove the iris hooks one by one. Perform a peripheral iridectomy as necessary.

Deepen the anterior chamber with additional viscoelastic. Apply viscoelastic to the corneal surface, apply a goniolens, and locate collector channels to identify sites for drainage device insertion. Lift the patient's head off of the head rest and rotate 30 degrees away from the surgeon. Rotate the operating microscope 30 degrees toward the surgeon. Re-apply the goniolens and adjust the microscope to visualize the chamber angle and nasal trabecular meshwork. Insert the drainage device inserter through the main incision and across the anterior chamber towards the nasal chamber angle. Retract the protective sleeve. Position the drainage device at the trabecular meshwork and insert into Schlemm's canal. Release the device from the injector. Tap the tip of the device to seat it firmly. Observe for blood reflux. Remove the injector and deepen the chamber with additional viscoelastic as needed. Re-insert the injector, retract the protective sleeve, position and insert the second drainage device approximately 2 clock-hours from the first. Tap to seat firmly, observe for blood reflux, and remove the injector.

Reposition the head and microscope vertically. Irrigate excess viscoelastic from the surface of the cornea. Reposition the IOL. Aspirate viscoelastic from the anterior chamber with the irrigation/aspiration handpiece. Inject a miotic drug into the anterior chamber to produce pupillary miosis as needed. Reform the eye with balanced salt solution and adjust the intraocular pressure to a physiologic range. Test the incisions for leaks and hydrate or suture any that leak. Remove the lid speculum. Place an antibiotic ointment on the eye as necessary. Place a soft patch and a rigid shield on the operative eye.

Description of Post-Service Work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Parag Parekh, MD (ASCRS); Emily Jones, MD (AAO/AGS)					
Specialty Society(ies):	American Academy of Ophthalmology (AAO) & American Society of Cataract and Refractive Surgery (ASCRS)					
CPT Code:	66989					
Sample Size:	2224	**Resp N:**	113			
Description of Sample:	Random sample of US practicing ophthalmologists of AAO, ASCRS, and the American Glaucoma Society (AGS)					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**12.00**	30.00	1500.00
Survey RVW:	4.25	12.13	**13.90**	15.02	25.00
Pre-Service Evaluation Time:			**26.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**7.00**		
Intra-Service Time:	10.00	21.00	**28.00**	36.00	69.00

Immediate Post Service-Time:	**8.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**92.00**	99211x **0.00** 12x **0.00** 13x **4.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	66989	**Recommended Physician Work RVU: 12.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**26.00**	**33.00**	**-7.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**7.00**	**15.00**	**-8.00**
Intra-Service Time:		**28.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7B Local/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**8.00**	**21.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66183	090	13.20	**RUC Time**

CPT Descriptor Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66179	090	14.00	**RUC Time**

CPT Descriptor Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36821	090	11.90	**RUC Time**	30,775

CPT Descriptor 1 Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
21025	090	10.03	**RUC Time**	3,614

CPT Descriptor 2 Excision of bone (eg, for osteomyelitis or bone abscess); mandible

Other Reference CPT Code	Global	Work RVU	Time Source
66982	090	10.25	**RUC Time**

CPT Descriptor Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 34 **% of respondents:** 30.0 **%**

Number of respondents who choose 2nd Key Reference Code: 27 **% of respondents:** 23.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 66989	Top Key Reference CPT Code: 66183	2nd Key Reference CPT Code: **66179**
Median Pre-Service Time	36.00	20.00	25.00
Median Intra-Service Time	28.00	45.00	55.00
Median Immediate Post-service Time	8.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	85.0	163.00	163.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**176.00**	**257.00**	**272.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	6%	32%	41%	21%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	41%	56%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	33%	67%
Physical effort required	3%	53%	43%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	32%	59%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	22%	48%	26%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	26%	67%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	19%	78%
Physical effort required	7%	44%	48%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	30%	63%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66989, *extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal)*

anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more is a new 090-day global CPT code combining complex cataract and IOL surgery with ab interno insertion of an aqueous drainage device for glaucoma. Use of these drainage devices is increasing in popularity because they offer the potential for pressure lowering without a full-thickness fistula and conjunctival bleb subject to scarring, infection, and failure due to over- or under-filtration.

This procedure has been reported since 2010 with CPT 0191T and CPT 66982. Claims volume for 0191T (57,829 in 2019) warranted creation of category I CPT codes combining cataract/IOL and drainage device procedures. Separate codes for device insertion with complex cataract/IOL surgery (66989) and standard cataract/IOL surgery (66991) were created. Both are being reviewed at this meeting.

Inadequate literature support and lack of FDA approval precluded creation of a category I CPT code for stand-alone drainage device insertion to replace 0191T, either as an add-on ZZZ or 090-day global. A new Category III code, 0671T, was created for the stand-alone procedure and is not being valued by the RUC at this time.

The entire family of cataract procedures, including CPT 66982, 66983, 66984, 66987, and 66988 was reviewed at the January 2019 RUC meeting. These codes do not need to be re-reviewed at this time because there have been no changes in the procedures: the typical physician work, patient population, technology, and site of service have not changed in many years, and certainly not since the last RUC valuation just two years ago.

Additionally, although CPT 66987 and 66988 were new CPT codes in 2020, they are not new technology. These two codes are combinations of long-existing procedures: endocyclophotocoagulation (CPT 66711) plus cataract (CPT 66982 or 66984). They were created by the Editorial Panel because CPT 66711 was being reported over 75% of the time with one of the cataract services.

We are therefore asking the RUC to reaffirm the values for CPT 66982, 66984, 66987, and 66988 that were determined two years ago.

For CPT 66989, a random survey of American Academy of Ophthalmology, American Society of Cataract and Refractive Surgeons, and American Glaucoma Society members had 113 respondents, 97% of whom found the vignette to be typical. The median WRVU was 13.90 and the 25th percentile was 12.13. The median IST was 28 minutes. The survey showed four 99213 postoperative visits. The expert panel of the AAO, ASCRS, and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings.

The top key reference service, chosen by 30% of respondents, was CPT 66183, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (RUC 2013), with a WRVU of 13.20, an IST of 45 minutes, and five level 3 and three level 2 postoperative visits. The second reference service, chosen by 24% of respondents, was CPT 66179, *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (RUC 2014), with a WRVU of 14.00, an IST of 55 minutes, and five level 3 and three level 2 postoperative visits. Both have substantially longer ISTs than the surveyed code related to the creation of a filtering conjunctival bleb, and a greater number of postoperative visits necessary to manage the bleb. The majority of respondents ranked the surveyed code as more or much more intense and complex on overall intensity and complexity and all submeasures compared to both key reference services with the exception of physical effort, where the majority ranked them identical. This is consistent with the surveyed code consisting of almost entirely intraocular work while a substantial portion of the reference code work, to create the conjunctival bleb, while on an open eye, is extraocular.

The panel noted that the median IST of 28 minutes for the combined procedure is 2 minutes shorter than the cataract procedure alone (CPT 66982). Surgeons who perform 66989 and 66991 were more likely to complete the survey than those who perform standalone cataract surgery but not the more complex combined procedures. These early adopters of the newer combined procedures are typically more skilled and experienced surgeons and are typically faster than the typical surgeon who performs cataract surgery alone and who would have responded to the cataract code survey in 2019. In addition, complex cataract surgery comprises a wide range of difficulties and times, with the “easier” 66982s being appropriate for use of the drainage device. This results in a false or

pseudo-inconsistency in the ISTs between these new combined codes and the standalone cataract surgery codes based upon the respondent profile. Surveying both the combined and standalone codes at this time would probably not resolve this anomaly because the new procedures have not yet diffused into the wider surgeon population.

We recognize that these codes will return for review in a few years under the New Technology screen, at which time the procedures will have diffused into a broader provider population. An array survey of the entire family, including the standalone cataract codes, should resolve this apparent anomaly once more surgeons are using it. Therefore, rather than discard the data and resurvey now, we accepted it as correct for the typical surgeon currently performing the procedure and proceeded with an attempt at valuation.

The panel agreed with the survey's 4 postoperative visits. We reduced one of the visits from a level 3 to a level 2. The level 2 visit is done on the first postoperative day to check vision, pressure, incision integrity, and level of inflammation. These patients typically have significantly greater than normal postoperative inflammation due to insertion of the device into uveal tissue and unstable IOP due to their glaucoma, as well as the potential for IOL dislocation and cystoid macular edema, necessitating more frequent dilated examinations in the postoperative period than stand-alone uncomplicated cataract surgery (CPT 66984). Dilated level 3 examinations are typical at 1, 2-4, and 6-10 weeks postoperatively because of the need for detailed examination of the posterior retina for macular edema, the peripheral retina for tears or detachments, and the peripheral intraocular lens implant for decentration and stability.

We chose pre-service package 3 (straightforward patient, difficult procedure) based on the comorbidity of poorly controlled glaucoma and the need for intraoperative repositioning requiring greater time for review and discussion in the preoperative area, and manipulation of sensitive uveal tissue requiring more profound local anesthesia with longer-lasting, slower-onset agents. These are typically complex, difficult to operate eyes with miotic pupils requiring a discussion of the multiple different options for lens fixation that may arise during surgery. This must also be reviewed by the physician and discussed with the patient to explain their effect on the potential length of the procedure and planned visual outcome.

We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 26 minutes. We reduced the survey positioning time from 5 minutes to match the package time of 3 minutes, and reduced the package pre-service scrub, dress and wait time from 15 minutes to the survey time of 7 minutes. We used the survey post-service time median of 8 minutes, which is less than the 21 minutes of post-service time package 7B (local anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 176 minutes, with an IST of 28 minutes.

We originally considered recommending the survey's 25th percentile work value, 12.31 RVU, for CPT 66989. However, this resulted in a very high IWPUT of 0.258. After considering reviewer comments and discussion at prefacilitation, the panel decided that this was not a supportable recommendation.

As with most intraocular procedures with relatively short ISTs and multiple postop visits, there are few if any eligible crosswalks. There are only nine 090-day global codes in the RUC database with ISTs between 25 and 30 minutes that have been reviewed within 10 years. The closest to the survey value and times is the standalone complex cataract surgery procedure CPT 66982, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation*. This was reviewed by the RUC in 2019 with a work value of 10.25 RVU, an IST of 30 minutes, and the same number and level of postoperative visits as the surveyed code. Because 66982 is up for reaffirmation at this meeting it is ineligible as a crosswalk. We also considered a crosswalk to the procedure used to crosswalk the value of CPT 66982 in 2019: CPT 67110, *Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)* (RUC 2015), with 10.25 WRVU, an IST of 30 minutes, and a total time of 196 minutes.

Logically there should be more work involved with the addition of the drainage device insertion despite the 2-minute shorter IST. Therefore, we considered other incremental and building block methods to value CPT 66989:

- Match the IWPUT to CPT 66982 (0.180), with a work value of 9.50 RVU;
- Apply the incremental value of the IST change at the IWPUT of CPT 66982, with a work value of 9.89 RVU

Both of these methods result in recommendations lower than the value of the standalone procedure, which the panel felt is even more paradoxical than a value equal to that of the base code.

We ultimately decided that a more accurate representation of physician work would be an incremental increase in WRVU equal to the difference in the survey 25th percentile work values between 66989 and 66991. This increment, 1.08 WRVU, was be added to our work value recommendation for 66991, 9.40 RVU, resulting in a recommendation of 10.48 WRVU for CPT 66989. This is a slightly greater work value than that of the standalone cataract procedure. This remains substantially below the survey 25th percentile value. It carries a high IWPUT, 0.199, but we are unable to devise any more accurate way to value the procedure until it has had time to diffuse into the broader population of ophthalmic surgeons.

We therefore recommend a work value of 10.48 WRVU for CPT 66989 (tracking number S2), with times of 36/28/8 and a total time of 176 minutes. We recommend that the procedure be flagged to not be used to value physician work and that it be placed on the New Technology list.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0191T and 66982

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 14000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate.

Specialty Ophthalmology Frequency 14000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,813
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate

Specialty Ophthalmology Frequency 6813 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Cataract removal/lens insertion

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 66982

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66991 Tracking Number S6 Original Specialty Recommended RVU: **11.05**
Presented Recommended RVU: **9.40**
Global Period: 090 Current Work RVU: **N/A** RUC Recommended RVU: **9.23**

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 69-year-old woman with a posterior subcapsular cataract who is no longer able to drive requires cataract removal and replacement with an intraocular lens. In addition, her increased intraocular pressure is not well controlled so placement of an aqueous drainage device through an internal approach is planned for the same time.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 14% , In the ASC 84%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications and pupillary dilation. Perform a surgical time out. Administer sub-Tenon or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface.

Description of Intra-Service Work: Insert a lid speculum. Position the microscope. Make a side-port incision 45 to 90 degrees away from the intended site of the surgical incision. Fill the anterior chamber with a viscoelastic. Create a temporal multiplanar limbal/corneal incision into the anterior chamber. Enter the eye through the main incision with a sharp bent needle to open the anterior capsule, followed by forceps to fashion a circular opening in the anterior capsule of the cataract. Insert a cannula into the eye to perform hydrodissection by injecting balanced salt solution between the lens cortex and capsule, loosening the nuclear and cortical layers of the lens in the process, while maintaining the integrity of the capsule. Hydrodelineate as needed by injecting fluid between the lens cortex and nucleus. Inject additional viscoelastic into the anterior chamber prior to phacoemulsification. Check the function of the phacoemulsification handpiece and the machine settings. Remove bubbles by tapping the handpiece with irrigation on. Insert the phacoemulsification tip into the eye and a second instrument through the side port incision. Using both hands and the foot actuated phaco pedal, carefully perform phacoemulsification with simultaneous aspiration of the lens nuclear material. Rotate and dis-assemble the lens to avoid inadvertent trauma to the cornea, lens capsule or iris. Add viscoelastic as needed to maintain a safe working space. Remove the phacoemulsification tip and second instrument from the eye. Introduce an irrigation and aspiration tip into the eye to aspirate the remainder of the cortical lens material. Then carefully vacuum and polish the interior surface of the thin lens capsule in an attempt to avoid future secondary membrane formation.

Adjust the size of the incision as needed to accommodate the intraocular lens (IOL). While maintaining traction on the eye via the side port incision, insert the tip of the IOL injection device into the main incision and place the IOL in the eye. Once in the eye, allow the IOL to unfold without damage to the cornea. Properly position and center the IOL into the capsular bag using a lens hook.

Deepen the anterior chamber with additional viscoelastic. Apply viscoelastic to the corneal surface, apply a goniolens, and locate collector channels to identify sites for drainage device insertion. Lift the patient's head off of the head rest and rotate 30 degrees away from the surgeon. Rotate the operating microscope 30 degrees toward the surgeon. Re-apply the goniolens and adjust the microscope to visualize the chamber angle and nasal trabecular meshwork. Insert the drainage device inserter through the main incision and across the anterior chamber towards the nasal chamber angle. Retract the protective sleeve. Position the drainage device at the trabecular meshwork and insert into Schlemm's canal. Release the device from the injector. Tap the tip of the device to seat it firmly. Observe for blood reflux. Remove the injector and deepen the chamber with additional viscoelastic as needed. Re-insert the injector, retract the protective sleeve, position and insert the second drainage device approximately 2 clock-hours from the first. Tap to seat firmly, observe for blood reflux, and remove the injector and gonio lens.

Reposition the head and microscope vertically. Irrigate excess viscoelastic from the surface of the cornea. Reposition the IOL. Aspirate viscoelastic from the anterior chamber with the irrigation/aspiration handpiece. Inject a miotic drug into the anterior chamber to produce pupillary miosis as needed. Reform the eye with balanced salt solution and adjust the intraocular pressure to a physiologic range. Test the incisions for leaks and hydrate or suture any that leak. Remove the lid speculum. Place an antibiotic ointment on the eye as necessary. Place a soft patch and a rigid shield on the operative eye.

Description of Post-Service Work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO): Parag Parekh, MD (ASCRS); Emily Jones, MD (AAO/AGS)					
Specialty Society(ies):	American Academy of Ophthalmology (AAO) & American Society of Cataract and Refractive Surgery (ASCRS)					
CPT Code:	66991					
Sample Size:	2224	**Resp N:**	114			
Description of Sample:	Random sample of US practicing ophthalmologists of AAO, ASCRS, and the American Glaucoma Society (AGS)					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	**36.50**	95.00	1500.00
Survey RVW:	1.15	11.05	**13.20**	14.00	35.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**6.50**		
Intra-Service Time:	4.00	19.25	**25.00**	30.00	57.00

Immediate Post Service-Time:	**8.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	66991	**Recommended Physician Work RVU: 9.23**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**7.00**	**15.00**	**-8.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7B Local/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**8.00**	**21.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66183	090	13.20	**RUC Time**

CPT Descriptor Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66179	090	14.00	**RUC Time**

CPT Descriptor Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
21025	090	10.03	**RUC Time**	3,614

CPT Descriptor 1 Excision of bone (eg, for osteomyelitis or bone abscess); mandible

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
14060	090	9.23	**RUC Time**	90,113

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
66982	090	10.25	**RUC Time**

CPT Descriptor Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 41 **% of respondents:** 35.9 **%**

Number of respondents who choose 2nd Key Reference Code: 15 **% of respondents:** 13.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 66991	Top Key Reference CPT Code: 66183	2nd Key Reference CPT Code: **66179**
Median Pre-Service Time	35.00	20.00	25.00
Median Intra-Service Time	25.00	45.00	55.00
Median Immediate Post-service Time	8.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	85.0	163.00	163.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**172.00**	**257.00**	**272.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	7%	17%	51%	24%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	34%	61%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	24%	76%
Physical effort required	2%	41%	56%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	12%	24%	63%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	13%	13%	47%	27%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	33%	53%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	13%	80%
Physical effort required	13%	33%	53%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	27%	53%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66991, *extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure),manual or mechanical technique(eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more)* is a new 090-day global CPT code combining cataract and IOL surgery with ab interno insertion of an aqueous drainage device for glaucoma.

Use of these drainage devices is increasing in popularity because they offer the potential for pressure lowering without a full-thickness fistula and conjunctival bleb subject to scarring, infection, and failure due to over- or under-filtration.

This procedure has been reported since 2010 with CPT 0191T and CPT 66984, without a multiple procedure payment reduction. Claims volume for 0191T (57,829 in 2019) warranted creation of category I CPT codes combining cataract/IOL and drainage device procedures. Separate codes for device insertion with complex cataract/IOL surgery (66989) and standard cataract/IOL surgery (66991) were created. Both are being reviewed at this meeting.

Inadequate literature support and lack of FDA approval precluded creation of a category I CPT code for stand-alone drainage device insertion, either as an add-on ZZZ or 090-day global. A new Category III code, 0671T, was created for the stand-alone procedure and is not being valued by the RUC at this time.

As discussed in the SOR for CPT 66989, we are asking for reaffirmation of the values for CPT 66982, 66984, 66987, and 66988 that were determined at the January 2019 RUC meeting.

For CPT 66991, a random survey of American Academy of Ophthalmology, American Society of Cataract and Refractive Surgeons, and American Glaucoma Society members had 114 respondents, 99% of whom found the vignette to be typical. The median WRVU was 13.20 and the 25th percentile was 11.05. The median IST was 25 minutes. The survey showed one 99212 and three 99213 postoperative visits. The expert panel of the AAO, ASCRS, and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings.

The top key reference service, chosen by 36% of respondents, was CPT 66183, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (RUC 2013), with a WRVU of 13.20, an IST of 45 minutes, and five level 3 and three level 2 postoperative visits. The second reference service, chosen by 13% of respondents, was CPT 66179, *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (RUC 2014), with a WRVU of 14.00, an IST of 55 minutes, and five level 3 and three level 2 postoperative visits. Both have substantially longer ISTs than the surveyed code related to the creation of a filtering conjunctival bleb, and a greater number of postoperative visits necessary to manage the bleb. The majority of respondents ranked the surveyed code as more or much more intense and complex on overall intensity and complexity and all of the submeasures compared to both key reference services. This is consistent with the surveyed code consisting of almost entirely intraocular work while a substantial portion of the reference code work, to create the conjunctival bleb, while on an open eye, is extraocular.

The panel accepted the survey median IST of 25 minutes although a differential of only 5 minutes over the IST for the corresponding standalone cataract procedure (CPT 66984) seemed low given the additional steps required to insert the drainage device. As discussed in the SOR for CPT 66989, the panel attributes this to the increased experience and speed of the early adapters likely to perform this procedure and complete the survey compared with the much greater number of surgeons who to date perform standalone cataract surgery alone.

The panel agreed with the number and level of postoperative visits. A level 2 visit is done on the first postoperative day to check vision, pressure, incision integrity, and level of inflammation. These patients typically have unstable IOP due to their glaucoma and greater than normal postoperative inflammation and risk of cystoid macular edema due to insertion of the device into uveal tissue. This necessitates more frequent dilated examinations in the postoperative period than stand-alone uncomplicated cataract surgery (CPT 66984). Three dilated level 3 examinations are typical, one each at approximately 1, 2-4, and 8-10 weeks postoperatively. These 3 dilated examinations are required for detailed examination of the posterior retina for macular edema and the peripheral retina for tears or detachments. This is more additional level 3 postop visit compared to the standalone uncomplicated cataract procedure (CPT 66984).

We chose pre-service package 3 (straightforward patient, difficult procedure) as with CPT 66989 based on the comorbidity of poorly controlled glaucoma and the need for intraoperative repositioning requiring greater time for review and explanation in the preoperative area, and manipulation of sensitive uveal tissue requiring more

profound local anesthesia. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 25 minutes. We reduced the survey positioning time from 5 minutes to match the package time of 3 minutes, and reduced the package pre-service scrub, dress and wait time from 15 minutes to the survey time of 7 minutes. We used the survey post-service time median of 8 minutes, which is less than the 21 minutes of post-service time package 7B (local anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 172 minutes, with an IST of 25 minutes.

As with the other code in this tab (66989), we considered the survey's 25th percentile work value, 11.05 RVU. After considering the associated IWPUT of 0.246 as well as comments from reviewers and at pre-facilitation, we decided that this was not a supportable value.

There are only 4 recently reviewed 090-day global CPT codes in the RUC database with 25-minute ISTs that have been reviewed within the past 10 years (CPT 46946, 53854, 67916, and 67923). All of them carry fewer postop visits, lower total times, and significantly lower work values (4.50-5.93 RVU) than standalone cataract surgery. The two ophthalmic procedures are extraocular eyelid repairs.

We therefore turned to an incremental approach, considering the following options:

1. Add increment of one additional level 3 postop visit (1.30 WRVU) to work value of CPT 66984, no added work value for additional 5 minutes IST over standalone:
    a. Work value: 8.65 RVU
    b. Differential over CPT 66984: +1.30 RVU
    c. IWPUT: 0.168
2. Match IWPUT to corresponding standalone cataract procedure CPT 66984 (0.191):
    a. Work value: 9.66 RVU
    b. Differential over CPT 66984: +2.31 RVU
    c. IWPUT: 0.191
3. Add incremental work value of 5 minutes increased IST at IWPUT of CPT 66984 (0.191), plus value of additional level 3 postop visit (1.30 WRVU) to work value of CPT 66984:
    a. Work value: 9.60
    b. Differential over CPT 66984: +2.25 RVU
    c. IWPUT: 0.188

Because CPT 66984 is flagged as not to be used to value physician work, we applied the IWPUT of CPT 66982, which has no similar restriction, to the incremental approach in Options 2 and 3:

4. Match IWPUT to standalone complex cataract procedure CTP 66982 (0.180):
    a. Work value: 9.40 RVU
    b. Differential over CPT 66984: +2.05 RVU
    c. IWPUT: 0.180
5. Add incremental work value of 5 minutes increased IST at IWPUT of CPT 66982 (0.180), plus value of additional level 3 postop visit (1.30 WRVU) to work value of CPT 66984:
    a. Work value: 9.55 RVU
    b. Differential over CPT 66984: +2.20 RVU
    c. IWPUT: 0.186

While none of these options is ideal, Option 4, matching the IWPUT to the standalone complex cataract procedure CPT 66982, is the only one which uses survey times with no reliance on the value of CPT 66984. The panel feels that this is consistent with our valuation method for CPT 66989 in that it offers no premium for being faster than the typical surgeon. It also results in an IWPUT in line with that of the standalone procedure. As with CPT 66989, this code will be reviewed with the standalone procedures under a New Technology flag within a few years. An array survey at that time, once more surgeons are familiar with the procedure, should return more uniform data. In the meantime, the recommended value is as accurate an estimate of physician work as possible and avoids carrier pricing.

We recommend a work value of 9.40 WRVU for CPT 66991, with times of 35/25/8 and a total time of 172 minutes. We recommend that the procedure be flagged to not be used to value physician work and that it be placed on the New Technology list.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0191T and 66984

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 145000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate.

Specialty Ophthalmology Frequency 145000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 72,205 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate.

Specialty Ophthalmology Frequency 72205 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Cataract removal/lens insertion

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 66984

SS Rec Summary

ISSUE: Cataract Removal with Drainage Device Insertion (66982, 66989, 66984, 66991, 66987, 66988)

TAB: 16

66989

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	66183	90	Insertion of ar	34	0.126	0.051			13.20			257	10	5	5			45			10					0.5				5	3						
2nd REF	66179	90	Aqueous shun	27	0.116	0.051			14.00			272	19	1	5			55			10					0.5				5	3						
CURRENT	0191T	XXX	Insertion of anterior																																		
CURRENT	66982	90	Extracapsular catara		0.180	0.059			10.25			175	25	3	7			30			6					0.5				3	1						
SVY	66989	90	Extracapsular	113	0.325	0.084	4.25	12.13	13.90	15.02	25.00	166	26	5	7	10	21	28	36	69	8								4					0	5	12	30	1500
REC	66989	90	Extracapsular catara		0.258	0.069			12.13			176	26	3	7			28			8					0.5				3	1						

66991

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	66183	90	Insertion of ar	41	0.126	0.051			13.20			257	10	5	5			45			10					0.5				5	3						
2nd REF	66179	90	Aqueous shun	15	0.116	0.051			14.00			272	19	1	5			55			10					0.5				5	3						
CURRENT	0191T	XXX	Insertion of anterior																																		
CURRENT	66984	90	Extracapsular catara		0.191	0.058			7.35			126	13	1	6			20			5					0.5				2	1						
SVY	66991	90	Extracapsular	114	0.356	0.085	1.15	11.05	13.20	14.00	35.00	155	25	5	6.5	4	19	25	30	57	8								3	1				0	15	37	95	1500
REC	66991	90	Extracapsular catara		0.173	0.054			9.23			172	25	3	7			25			8					0.5				3	1						

Reaffirming 66982, 66984, 66987, and 66988

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
RUC	66982	90	Extracapsular catara		0.180	0.059			10.25			175	25	3	7			30			6					0.5				3	1						
RUC	66984	90	Extracapsular catara		0.191	0.058			7.35			126	13	1	6			20			5					0.5				2	1						
RUC	66987	90	Extracapsular catara		0.170	0.055			13.15			239	30	3	10			36			10					0.5				5	1						
RUC	66988	90	Extracapsular catara		0.146	0.051			10.25			202	25	3	10			30			7					0.5				4	1						

FACILITY DIRECT PE INPUTS **CPTCODE(S):_66989___**
SPECIALTY SOCIETY(IES):__AAO, ASCRS_____
PRESENTER(S):_Ankoor Shah, David Glasser, Emily Jones, and Parag Parekh__

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
66989	A 74-year-old man with a cortical cataract severe enough to no longer allow vision for reading who requires cataract removal and replacement with an intraocular lens. He has a history of use of systemic medications causing floppy iris syndrome and the intraoperative use of an iris retraction device is planned. In addition, his increased intraocular pressure is not well controlled on two topical medications so placement of an aqueous drainage device through an internal approach is planned at the same time.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. The consensus committee considered the survey data and PE details to determine clinical time. Additionally, applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Reference Code is 66982. This is the code for complex cataract surgery, but without placement of an aqueous drainage device.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Cataract surgery with placement of an aqueous drainage device is a major surgery with a 90-day global. Standard inputs are used during the pre-service period consistent with PEAC recommendations for 90-day global procedures.

   b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

   c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam.

Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used. Screening lane: Standard office visit formula used.

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPTCODE(S):_66991___**

SPECIALTY SOCIETY(IES):__AAO, ASCRS_____

PRESENTER(S):_Ankoor Shah, David Glasser, Emily Jones, and Parag Parekh__

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
66991	A 69-year-old woman with a posterior subcapsular cataract who is no longer able to drive requires cataract removal and replacement with an intraocular lens. In addition, her increased intraocular pressure is not well controlled so placement of an aqueous drainage device through an internal approach is planned for the same time.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. The consensus committee considered the survey data and PE details to determine clinical time. Additionally, applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Reference Code is 66984. This is the code for cataract surgery, but without placement of an aqueous drainage device.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Cataract surgery with placement of an aqueous drainage device is a major surgery with a 90-day global. Standard inputs are used during the pre-service period consistent with PEAC recommendations for 90-day global procedures.

   b. Service period (includes pre, intra and post):

This time accounts for the standard inputs of same day discharge management.

   c. Post-service period:

This time accounts for staff time during postoperative visits. Standard times were used based on the level of postoperative office visit as determined by the RUC-approved survey data for this code.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Ophthalmology pack for dilated eye exams – utilized on visits requiring a dilated exam. Ophthalmology pack for non-dilated eye exams – utilized on non-dilated postoperative visits.

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Exam lane: Standard office visit formula used. Screening lane: Standard office visit formula used.

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		CUR
2						66982		66982		66
3		***RUC Collaboration Website***				Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure),		Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure),		Extrac cataract ex insertion of lens pros stage pr
4	Clinical Activity Code	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 15 Specialty: AAO, ASCRS**	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**					**090**		**090**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 106.14**	**$ -**	**$ 106.14**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**201.0**	**0.0**	**201.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**135.0**	**0.0**	**135.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 76.38**	**$ -**	**$ 76.38**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**	L038A							
15	CA001	Complete pre-service diagnostic and referral forms	L038A	COMT/COT/RN/CST	0.38		5		5	
16	CA002	Coordinate pre-surgery services (including test results)	L038A	COMT/COT/RN/CST	0.38		20		20	
17	CA003	Schedule space and equipment in facility	L038A	COMT/COT/RN/CST	0.38		8		8	
18	CA004	Provide pre-service education/obtain consent	L038A	COMT/COT/RN/CST	0.38		20		20	
19	CA005	Complete pre-procedure phone calls and prescription	L038A	COMT/COT/RN/CST	0.38		7		7	
20	CA006	Confirm availability of prior images/studies	L038A	COMT/COT/RN/CST	0.38					
21	CA007	Review patient clinical extant information and questionnaire	L038A	COMT/COT/RN/CST	0.38					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L038A	COMT/COT/RN/CST	0.38					
23			L038A	COMT/COT/RN/CST	0.38					
26		*Other activity: please include short clinical description here and type new in column A*	L038A	COMT/COT/RN/CST	0.38					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L038A	COMT/COT/RN/CST	0.38					
34	CA010	Obtain vital signs	L038A	COMT/COT/RN/CST	0.38					
35	CA011	Provide education/obtain consent	L038A	COMT/COT/RN/CST	0.38					
36	CA012	Review requisition, assess for special needs	L038A	COMT/COT/RN/CST	0.38					
37	CA013	Prepare room, equipment and supplies	L038A	COMT/COT/RN/CST	0.38					
38	CA014	Confirm order, protocol exam	L038A	COMT/COT/RN/CST	0.38					
39	CA015	Setup scope (nonfacility setting only)	L038A	COMT/COT/RN/CST	0.38					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COT/RN/CST	0.38					
41	CA017	Sedate/apply anesthesia	L038A	COMT/COT/RN/CST	0.38					
42			L038A	COMT/COT/RN/CST	0.38					
45		*Other activity: please include short clinical description here and type new in column A*	L038A	COMT/COT/RN/CST	0.38					
48		**Intra-service (of service period)**								
49	CA018	Assist physician of other qualified healthcare professional---directly related to physician work time (other%)	L038A	COMT/COT/RN/CST	0.38					
50	CA019	Assist physician of other qualified healthcare professional---directly related to physician work time (other%)	L038A	COMT/COT/RN/CST	0.38					
51	CA020	Assist physician of other qualified healthcare professional---directly related to physician work time (other%)	L038A	COMT/COT/RN/CST	0.38					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L038A	COMT/COT/RN/CST	0.38					
55			L038A	COMT/COT/RN/CST	0.38					
56		*Other activity: please include short clinical description here and type new in column A*	L038A	COMT/COT/RN/CST	0.38					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L038A	COMT/COT/RN/CST	0.38					
61	CA023	Monitor patient following procedure/service, no multitasking	L038A	COMT/COT/RN/CST	0.38					
62	CA024	Clean room/equipment by clinical staff	L038A	COMT/COT/RN/CST	0.38					
63	CA025	Clean scope	L038A	COMT/COT/RN/CST	0.38					
64	CA026	Clean surgical instrument package	L038A	COMT/COT/RN/CST	0.38					
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L038A	COMT/COT/RN/CST	0.38					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L038A	COMT/COT/RN/CST	0.38					
67	CA029	Check dressings, catheters, wounds	L038A	COMT/COT/RN/CST	0.38					
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, marked	L038A	COMT/COT/RN/CST	0.38					
69	CA031	Review examination with interpreting MD/DO	L038A	COMT/COT/RN/CST	0.38					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into workqueue	L038A	COMT/COT/RN/CST	0.38					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L038A	COMT/COT/RN/CST	0.38					
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L038A	COMT/COT/RN/CST	0.38					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L038A	COMT/COT/RN/CST	0.38					
74	CA036	Discharge day management	L038A	COMT/COT/RN/CST	0.38	n/a	6	n/a	6	n/a
75			L038A	COMT/COT/RN/CST	0.38					
78		*Other activity: please include short clinical description here and type new in column A*	L038A	COMT/COT/RN/CST	0.38					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L038A	COMT/COT/RN/CST	0.38					
85	CA038	Coordinate post-procedure services	L038A	COMT/COT/RN/CST	0.38					
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27				1		1	
89		99213 36 minutes	36				3		3	
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L038A	COMT/COT/RN/CST	0.38	**0.0**	**135.0**	**0.0**	**135.0**	**0.0**
93			L038A	COMT/COT/RN/CST	0.38					
96		*Other activity: please include short clinical description here and type new in column A*	L038A	COMT/COT/RN/CST	0.38					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CUR**
2						**66982**		**66982**		**66**
3		***RUC Collaboration Website***				Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure),		Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure),		Extrac cataract ex insertion of lens pros stage pr
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 15 Specialty: AAO, ASCRS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**					**090**		**090**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 106.14**	**$ -**	**$ 106.14**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**201.0**	**0.0**	**201.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**135.0**	**0.0**	**135.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 12.63**	**$ -**	**$ 12.63**	**$ -**
102	SA082	pack, ophthalmology visit (w-dilation)	3.4318	pack			3		3	
103	SA050	pack, ophthalmology visit (no dilation)	2.3363	pack			1		1	
104										
105										
106										
107										
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ 17.13**	**$ -**	**$ 17.13**	**$ -**
112	EL005	lane, exam (oph)	40526.8425		0.127283043		108		108.0	
113	EL006	lane, screening (oph)	39874.4787		0.125234158		27		27	
114										
115										
116										
117										
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	L	M	N	O	P	Q	R	S	T
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**984**	**66984**		**66987**		**66987**		**66988**	
3		***RUC Collaboration Website***	apsular	Extracapsular		Extracapsular		Extracapsular		Extracapsular	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAO, ASCRS**	traction w/ intraocular thesis (1 ocedure),	cataract extraction w/ insertion of intraocular lens prosthesis (1 stage		cataract removal with insertion of intraocular lens prosthesis (1-stage procedure),		cataract removal with insertion of intraocular lens prosthesis (1-stage		cataract removal with insertion of intraocular lens prosthesis (1 stage procedure),	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**		**090**		**090**		**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 84.45**	**$ -**	**$ 84.45**	**$ -**	**$ 149.53**	**$ -**	**$149.53**	**$ -**	**$ 127.83**
8		**TOTAL CLINICAL STAFF TIME**	**165.0**	**0.0**	**165.0**	**0.0**	**273.0**	**0.0**	**273.0**	**0.0**	**237.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**99.0**	**0.0**	**99.0**	**0.0**	**207.0**	**0.0**	**207.0**	**0.0**	**171.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 62.70**	**$ -**	**$ 62.70**	**$ -**	**$ 103.74**	**$ -**	**$ 103.74**	**$ -**	**$ 90.06**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms	5		5		5		5		5
16	CA002	Coordinate pre-surgery services (including test results)	20		20		20		20		20
17	CA003	Schedule space and equipment in facility	8		8		8		8		8
18	CA004	Provide pre-service education/obtain consent	20		20		20		20		20
19	CA005	Complete pre-procedure phone calls and prescription	7		7		7		7		7
20	CA006	Confirm availability of prior images/studies									
21	CA007	Review patient clinical extant information and questionnaire									
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)									
23											
26		*Other activity: please include short clinical description here and type new*									
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are									
34	CA010	Obtain vital signs									
35	CA011	Provide education/obtain consent									
36	CA012	Review requisition, assess for special needs									
37	CA013	Prepare room, equipment and supplies									
38	CA014	Confirm order, protocol exam									
39	CA015	Setup scope (nonfacility setting only)									
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient									
41	CA017	Sedate/apply anesthesia									
42											
45		*Other activity: please include short clinical description here and type new*									
48		**Intra-service (of service period)**									
49	CA018	Assist physician of other qualified healthcare professional---directly related									
50	CA019	Assist physician of other qualified healthcare professional---directly related									
51	CA020	Assist physician of other qualified healthcare professional---directly related									
52	CA021	Perform procedure/service---NOT directly related to physician work time									
55											
56		*Other activity: please include short clinical description here and type new*									
59		**Post-Service (of service period)**									
60	CA022	Monitor patient following procedure/service, multitasking 1:4									
61	CA023	Monitor patient following procedure/service, no multitasking									
62	CA024	Clean room/equipment by clinical staff									
63	CA025	Clean scope									
64	CA026	Clean surgical instrument package									
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions									
66	CA028	Review/read post-procedure x-ray, lab and pathology reports									
67	CA029	Check dressings, catheters, wounds									
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,									
69	CA031	Review examination with interpreting MD/DO									
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to									
71	CA033	Perform regulatory mandated quality assurance activity (service period)									
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs,									
73	CA035	Review home care instructions, coordinate visits/prescriptions									
74	CA036	Discharge day management	6	n/a	6	n/a	6	n/a	6	n/a	6
75											
78		*Other activity: please include short clinical description here and type new*									
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037	Conduct patient communications									
85	CA038	Coordinate post-procedure services									
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes									
88		99212 27 minutes	1		1		1		1		1
89		99213 36 minutes	2		2		5		5		4
90		99214 53 minutes									
91		99215 63 minutes									
92	CA039	Post-operative visits (total time)	**99.0**	**0.0**	**99.0**	**0.0**	**207.0**	**0.0**	**207.0**	**0.0**	**171.0**
93											
96		*Other activity: please include short clinical description here and type new*									
99		**End: with last office visit before end of global period**									

	A	B	L	M	N	O	P	Q	R	S	T
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**984**	**66984**		**66984**		**66987**		**66988**	
3		***RUC Collaboration Website***	apsular	Extracapsular		Extracapsular		Extracapsular		Extracapsular	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAO, ASCRS**	traction w/ intraocular thesis (1 ocedure),	cataract extraction w/ insertion of intraocular lens prosthesis (1 stage		cataract removal with insertion of intraocular lens prosthesis (1-stage procedure),		cataract removal with insertion of intraocular lens prosthesis (1-stage		cataract removal with insertion of intraocular lens prosthesis (1 stage procedure),	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**		**090**		**090**		**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 84.45**	**$ -**	**$ 84.45**	**$ -**	**$ 149.53**	**$ -**	**$149.53**	**$ -**	**$ 127.83**
8		**TOTAL CLINICAL STAFF TIME**	**165.0**	**0.0**	**165.0**	**0.0**	**273.0**	**0.0**	**273.0**	**0.0**	**237.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**99.0**	**0.0**	**99.0**	**0.0**	**207.0**	**0.0**	**207.0**	**0.0**	**171.0**
100	**Supply Code**	**MEDICAL SUPPLIES**									
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 9.20**	**$ -**	**$ 9.20**	**$ -**	**$ 19.50**	**$ -**	**$ 19.50**	**$ -**	**$ 16.06**
102	SA082	pack, ophthalmology visit (w-dilation)	2		2		5		5		4
103	SA050	pack, ophthalmology visit (no dilation)	1		1		1		1		1
104											
105											
106											
107											
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
110	**Equipment Code**	**EQUIPMENT**									
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 12.55**	**$ -**	**$ 12.55**	**$ -**	**$ 26.29**	**$ -**	**$ 26.29**	**$ -**	**$ 21.71**
112	EL005	lane, exam (oph)	72		72.0		180		180.0		144
113	EL006	lane, screening (oph)	27		27		27		27		27
114											
115											
116											
117											
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	U	V	W	X	Y	Z
1	RUC Practice Expense Spreadsheet		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2			66988		66989		66991	
3		***RUC Collaboration Website***	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage		Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage		Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage	
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 15 Specialty: AAO, ASCRS**						
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		**090**		**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$127.83**	**$ -**	**$106.14**	**$ -**	**$106.14**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**237.0**	**0.0**	**201.0**	**0.0**	**201.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**171.0**	**0.0**	**135.0**	**0.0**	**135.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ 90.06**	**$ -**	**$ 76.38**	**$ -**	**$ 76.38**
13		**PRE-SERVICE PERIOD**						
14		**Start: Following visit when decision for surgery/procedure made**						
15	CA001	Complete pre-service diagnostic and referral forms		5		5		5
16	CA002	Coordinate pre-surgery services (including test results)		20		20		20
17	CA003	Schedule space and equipment in facility		8		8		8
18	CA004	Provide pre-service education/obtain consent		20		20		20
19	CA005	Complete pre-procedure phone calls and prescription		7		7		7
20	CA006	Confirm availability of prior images/studies						
21	CA007	Review patient clinical extant information and questionnaire						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)						
23								
26		*Other activity: please include short clinical description here and type new in column A*						
29		**End: When patient enters office/facility for surgery/procedure**						
30		**SERVICE PERIOD**						
31		**Start: When patient enters office/facility for surgery/procedure:**						
32		**Pre-Service (of service period)**						
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are [illegible]						
34	CA010	Obtain vital signs						
35	CA011	Provide education/obtain consent						
36	CA012	Review requisition, assess for special needs						
37	CA013	Prepare room, equipment and supplies						
38	CA014	Confirm order, protocol exam						
39	CA015	Setup scope (nonfacility setting only)						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient						
41	CA017	Sedate/apply anesthesia						
42								
45		*Other activity: please include short clinical description here and type new in column A*						
48		**Intra-service (of service period)**						
49	CA018	Assist physician or other qualified healthcare professional---directly related						
50	CA019	Assist physician or other qualified healthcare professional---directly related						
51	CA020	Assist physician or other qualified healthcare professional---directly related						
52	CA021	Perform procedure/service---NOT directly related to physician work time						
55								
56		*Other activity: please include short clinical description here and type new in column A*						
59		**Post-Service (of service period)**						
60	CA022	Monitor patient following procedure/service, multitasking 1:4						
61	CA023	Monitor patient following procedure/service, no multitasking						
62	CA024	Clean room/equipment by clinical staff						
63	CA025	Clean scope						
64	CA026	Clean surgical instrument package						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports						
67	CA029	Check dressings, catheters, wounds						
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, [illegible]						
69	CA031	Review examination with interpreting MD/DO						
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to [illegible]						
71	CA033	Perform regulatory mandated quality assurance activity (service period)						
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, [illegible]						
73	CA035	Review home care instructions, coordinate visits/prescriptions						
74	CA036	Discharge day management	n/a	6	n/a	6	n/a	6
75								
78		*Other activity: please include short clinical description here and type new in column A*						
81		**End: Patient leaves office/facility**						
82		**POST-SERVICE PERIOD**						
83		**Start: Patient leaves office/facility**						
84	CA037	Conduct patient communications						
85	CA038	Coordinate post-procedure services						
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes						
88		99212 27 minutes		1		1		1
89		99213 36 minutes		4		3		3
90		99214 53 minutes						
91		99215 63 minutes						
92	CA039	Post-operative visits (total time)	**0.0**	**171.0**	**0.0**	**135.0**	**0.0**	**135.0**
93								
96		*Other activity: please include short clinical description here and type new in column A*						
99		**End: with last office visit before end of global period**						

	A	B	U	V	W	X	Y	Z
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2			**66988**		**66989**		**66991**	
3		***RUC Collaboration Website***	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage		Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage		Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 15** **Specialty: AAO, ASCRS**						
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		**090**		**090**		**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$127.83**	**$ -**	**$106.14**	**$ -**	**$106.14**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**237.0**	**0.0**	**201.0**	**0.0**	**201.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**171.0**	**0.0**	**135.0**	**0.0**	**135.0**
100	**Supply Code**	**MEDICAL SUPPLIES**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ 16.06**	**$ -**	**$ 12.63**	**$ -**	**$ 12.63**
102	SA082	pack, ophthalmology visit (w-dilation)		4		3		3
103	SA050	pack, ophthalmology visit (no dilation)		1		1		1
104								
105								
106								
107								
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*						
110	**Equipment Code**	**EQUIPMENT**						
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ 21.71**	**$ -**	**$ 17.13**	**$ -**	**$ 17.13**
112	EL005	lane, exam (oph)		144.0		108.0		108.0
113	EL006	lane, screening (oph)		27		27		27
114								
115								
116								
117								
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Codes Reported Together 75% or More

January 2019

Cyclophotocoagulation Cataract Surgery – Tab 11

In October 2017, CPT codes 66711 and 66984 were identified as codes reported together 75% of the time or more. The RUC reviewed action plans to determine whether a code bundle solution should be developed for these services. In January 2018, the RUC recommended to refer to CPT to bundle 66711 with 66984 for CPT 2020. In May 2018, the CPT Editorial Panel revised three codes and created two new codes to differentiate cataract procedures performed with and without endoscopic cyclophotocoagulation.

66711 ***Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens***
The RUC reviewed the survey results from 40 ophthalmologists and determined to crosswalk the work RVU of 6.36 from key reference service code 67210 *Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation* (work RVU = 6.36 and 15 minutes intra-service time) to CPT code 66711. The RUC conducted a thorough search of all other potential crosswalk codes and ran into a lack of potential crosswalk codes due to the lack of similarly intense major surgical procedures with a comparable amount of skin-to-skin time, OR time and amount of post-operative care. The RUC noted that the survey intra-service time decreased 10 minutes from the current time and that the only appropriate crosswalk for this intense intraocular service is CPT code 67210. The survey respondents indicated that 66711 is more intense and complex to perform than 67210 on all measures examined (mental effort/judgment, technical skill/physical effort and psychological stress). Additionally, both services use laser ablation of tissue, making it the most clinically relatable service for comparison.

The RUC recommends 25 minutes pre-service evaluation, 3 minutes pre-service positioning, 6 minutes pre-service scrub/dress/wait pre-service time, 20 minutes intra-service time, 10 minutes immediate post-time, half a discharge day management (99238), four 99213 office visits and one 99212 office visit. The first post-operative visit is a 99212 visit on the first day after surgery in which the physician performs an exam on an un-dilated eye, checking visual acuity, intraocular pressure, incision integrity, and level of inflammation. The remaining four post-operative visits are 99213 visits approximately 1 week, 2 weeks, 1 month and 6-8 weeks postoperatively, in which the physician performs an exam on a dilated eye, checking visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema. These exams must be performed on a dilated eye, as specified by practice guidelines, to check for macular edema and ensure that retinal detachment has not occurred. **The RUC recommends a work RVU of 6.36 for CPT code 66711.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Complex Cataract Removal

66982 ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation***

The RUC reviewed the survey results from 92 ophthalmologists and determined to crosswalk the work RVU of 10.25 from CPT code 67110 *Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)* (work RVU = 10.25 and 30 minutes intra-service time) to CPT code 66982. The RUC noted that the survey top key reference codes 67036 *Vitrectomy, mechanical, pars plana approach;* (work RVU = 12.13, IWPUT = 0.1075) and 65850 *Trabeculotomy ab externo* (work RVU = 11.39, IWPUT = 0.1109) have a much lower physician work intensity than the surveyed code and therefore it would be appropriate for the survey code to have a higher intra-service work per unit of time (IWPUT). The intensity of cataract surgery has not changed and the magnitude estimation in the survey data supports that the intensity of this service is high. All the intra-service time for cataract surgery is spent with both the physicians' hands inside the eye and both feet managing ultrasound and microscope foot pedals, where a slight misstep can lead to serious complications such as endophthalmitis or retinal detachment with permanent loss of vision, which contributes to the intensity of the procedure. The RUC conducted a thorough search of all other potential crosswalk codes and ran into a lack of potential crosswalk codes due to the lack of similarly intense major surgical procedures with a comparable amount of skin-to-skin time, OR time and amount of post-operative care. The RUC noted that the only appropriate crosswalk for this intense service is 67110. CPT code 66982 has less total time than 67110, but that is due to the difference in post-operative visits required for these services. Both CPT codes 66982 and 67110 require the same intra-service time of 30 minutes and CPT code 66982 is appropriately more intense than CPT code 67110. CPT code 67110 involves an injection of air into the vitreous to tamponade the retinal detachment and there is relativity less intraocular manipulation. Whereas, the intra-service work for 66982 includes work all performed inside the eye.

The RUC recommends 25 minutes evaluation, 3 minutes positioning, 7 minutes scrub/dress/wait pre-service time, 30 minutes intra-service time, 6 minutes immediate post-time, half a discharge day management (99238), three 99213 office visits and one 99212 office visit. The first post-operative visit is a 99212 visit on the first day after surgery in which the physician performs an exam on an un-dilated eye, checking visual acuity, intraocular pressure, incision integrity, and level of inflammation. The remaining three post-operative visits are 99213 visits approximately 1 week, 2-4 weeks, and 6-8 weeks postoperatively, in which the physician performs an exam on a dilated eye, checking visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema and peripheral retina for tears or detachments. These exams must be performed on a dilated eye, as specified by practice guidelines, to ensure that retinal detachment has not occurred. **The RUC recommends a work RVU of 10.25 for CPT code 66982.**

66987 ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation***

The RUC reviewed the survey results from 31 ophthalmologists and determined a work RVU of 13.15 appropriately accounts for the work required to perform this service. The RUC conducted a thorough search of all other potential crosswalk codes and noted a lack of potential crosswalk codes due to the complete lack of similarly intense major surgical procedures with a comparable amount of skin-to-skin time, OR time

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

and amount of post-operative care. There are no available crosswalks to the physician work, time and intensity of this service. Therefore, the RUC used an increment approach by adding the RUC recommended difference of the standard cataract removal with endoscopic cyclophotocoagulation (CPT code 66988 RUC recommended work RVU = 10.25) compared to the standard cataract removal without endoscopic cyclophotocoagulation (CPT code 66984, RUC recommended work RVU = 7.35), which results in 2.90 (10.25 - 7.35 = 2.90). Therefore, adding the work of the endoscopic cyclophotocoagulation (2.90) to the RUC recommendation for CPT code 66982 complex cataract removal without endoscopic cyclophotocoagulation (RUC recommended work RVU = 10.25), (10.25 + 2.90 = 13.15) results in 13.15 work RVUs.

The RUC noted that the survey top key reference codes 66179 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (work RVU = 14.00, 55 minutes intra-service time and IWPUT = 0.1156) and 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* (work RVU = 15.36, 90 minutes intra-service time and IWPUT = 0.0743) have a much higher intra-service time and lower IWPUT than what would be appropriate for the much more intense surveyed code. The intensity of cataract surgery has not changed and the magnitude estimation in the survey data supports that the intensity of this service is high. All the intra-service time for cataract surgery is spent with both the physicians' hands inside the eye and both feet managing ultrasound and microscope foot pedals, where a slight misstep can lead to serious complications such as endophthalmitis or retinal detachment with permanent loss of vision, which contributes to the intensity of the procedure.

The RUC recommends 30 minutes pre-service evaluation, 3 minutes pre-service positioning, 10 minutes pre-service scrub/dress/wait time, 36 minutes intra-service time, 10 minutes immediate post-time, half a discharge day management (99238), five 99213 office visits and one 99212 office visit. The first post-operative visit is a 99212 visit on the first day after surgery in which the physician performs an exam on an un-dilated eye, checking visual acuity, intraocular pressure, incision integrity, and level of inflammation. The remaining five post-operative visits are 99213 visits approximately 1, 2, 3-4, 6-8, and 10-12 weeks postoperatively, in which the physician performs an exam on a dilated eye, to check visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema and peripheral retina for tears or detachments. These exams must be performed on a dilated eye, as specified by practice guidelines, to check for macular edema and ensure that retinal detachment has not occurred. **The RUC recommends a work RVU of 13.15 for CPT code 66987.**

Cataract Removal

66983 ***Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)***
This service is performed less than 150 times in the Medicare population and the specialty society, with the RUC's approval, did not attempt to survey this service. Based on the Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF CY2016 file, only one ophthalmologist reported this service more than 10 times. **The RUC recommends that this service be contractor priced.**

66984 ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation***
The RUC reviewed the survey results from 93 ophthalmologists and determined a work RVU of 7.35 appropriately accounts for the work required to perform this service. The RUC used an incremental approach by taking the value of similar service 67210 *Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation* (work RVU = 6.36 and 15 minutes intra-service time, IWPUT = 0.1991) and added the intensity for 5 additional intra-service minutes associated with 66984 (20 minutes intra-service time). (5 minutes x 0.1991

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

intensity of CPT code 67210 = 0.99, 6.36 + 0.99 = 7.35). The RUC conducted a thorough search of all other potential crosswalk codes and ran into a lack of potential crosswalk codes due to the complete lack of similarly intense major surgical procedures with a comparable amount of skin-to-skin time, OR time and amount of post-operative care. The RUC noted there are no distinct crosswalks to support the intensity of this service and the only appropriate code to reference with similar intensity is 67210. A minority of those surveyed, chose CPT code 67210 as a top key reference service and ranked the intensity and complexity of 66984 as somewhat more to much more than 67210. The specialty societies indicated that as an intraocular procedure, 66984 is much more intense and complex than 67210, which is an extraocular laser procedure with a contact lens placed on the eye.

The RUC noted that the survey top key reference codes 65850 *Trabeculotomy ab externo* (work RVU = 11.39, IWPUT = 0.1109) and 66184 *Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft* (work RVU = 9.58, IWPUT = 0.0485) have a much lower IWPUT than what would be appropriate for the much more intense surveyed code. The intensity of cataract surgery has not changed and the magnitude estimation in the survey data supports that the intensity of this service is high. All the intra-service time for cataract surgery is spent with both the physicians' hands inside the eye and both feet managing ultrasound and microscope foot pedals, where a slight misstep can lead to serious complications such as endophthalmitis or retinal detachment with permanent loss of vision, which contribute to the intensity of the procedure.

The RUC recommends 13 minutes pre-service evaluation, 1 minutes pre-service positioning, 6 minutes pre-service scrub/dress/wait time, 20 minutes intra-service time, 5 minutes immediate post-service time, half a discharge day management (99238), two 99213 office visits and one 99212 office visit. The first post-operative visit is a 99212 visit on the first day after surgery in which the physician performs an exam on an un-dilated eye, checking visual acuity, intraocular pressure, incision integrity, and level of inflammation. The remaining two post-operative visits are 99213 visits approximately one week and one month postoperatively to check visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema and peripheral retina for tears or detachments. These exams must be performed on a dilated eye as specified by practice guidelines, to check for macular edema and ensure that retinal detachment has not occurred. **The RUC recommends a work RVU of 7.35 for CPT code 66984.**

66988 ***Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation***
The RUC reviewed the survey results from 31 ophthalmologists and determined to crosswalk the work RVU of 10.25 from CPT code 67110 *Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)* (work RVU = 10.25 and 30 minutes intra-service time) to this service. The RUC noted that the survey top key reference codes 66179 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (work RVU = 14.00, 55 minutes intra-service time and IWPUT = 0.1156) and 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* (work RVU = 15.36, 90 minutes intra-service time and IWPUT = 0.0743) have much higher intra-service time and lower IWPUT than what would be appropriate for the much more intense surveyed code. The intensity of cataract surgery has not changed and the magnitude estimation in the survey data supports that the intensity of this service is high. All the intra-service time for cataract surgery is spent with both the physicians' hands inside the eye and both feet managing ultrasound and microscope foot pedals, where a slight misstep can lead to serious complications such as endophthalmitis or retinal detachment with permanent loss of vision, which contributes to the intensity of the procedure. The RUC conducted a thorough search of all other potential crosswalk codes and ran into a lack of potential crosswalk codes due to the lack of similarly intense major surgical procedures with a comparable amount of skin-to-skin time, OR

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

time and amount of post-operative care. The RUC noted the only appropriate crosswalk for this intense service is 67110. CPT code 66988 has similar total time and the same intra-service time of 30 minutes. CPT code 66988 is appropriately more intense than CPT code 67110. CPT code 67110 involves an injection of air into the vitreous to tamponade the retinal detachment and there is relativity less intraocular manipulation. Whereas, the intra-service work for 66988 includes work all performed inside the eye.

The RUC recommends 25 minutes pre-service evaluation, 3 minutes pre-service positioning, 10 minutes pre-service scrub/dress/wait time, 30 minutes intra-service time, 7 minutes immediate post-time, half a discharge day management (99238), four 99213 office visits and one 99212 office visit. The first post-operative visit is a 99212 visit on the first day after surgery in which the physician performs an exam on an undilated eye, checking visual acuity, intraocular pressure, incision integrity, and level of inflammation. The remaining four post-operative visits are 99213 visits approximately 1, 2, 4, and 6-8 weeks postoperatively, in which the physician performs an exam on a dilated eye, to check visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema and peripheral retina for tears or detachments. These exams must be performed on a dilated eye, as specified by practice guidelines, to check for macular edema and ensure that retinal detachment has not occurred. **The RUC recommends a work RVU of 10.25 for CPT code 66988.**

Flag
The value for CPT codes 66984 and 66987 were established using a building block methodology, the RUC notes that they should be flagged as "**Do not use to validate for physician work."**

Practice Expense
The RUC recommends the standard 090-day global period direct practice expense inputs as submitted by the specialty society.

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

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Eye and Ocular Adnexa**				
▲66711	I1	Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens (For endoscopic cyclophotocoagulation performed at same encounter as extracapsular cataract removal with intraocular lens insertion, see 66987, 66988) *(Do not report 66711 in conjunction with 66990)*	090	6.36

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

▲66982	I2	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation *(For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)* (For complex extracapsular cataract removal with concomitant endoscopic cyclophotocoagulation, use 66987)	090	10.25
●66987	I3	with endoscopic cyclophotocoagulation (For complex extracapsular cataract removal without endoscopic cyclophotocoagulation, use 66982) (For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)	090	13.15
(f)66983	I4	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure) *(Do not report 66983 in conjunction with 0308T)*	090	Contractor Price
▲66984	I5	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation *(For complex extracapsular cataract removal, use 66982)* (For extracapsular cataract removal with concomitant endoscopic cyclophotocoagulation, use 66988) *(For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)*	090	7.35

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

●66988	I6	with endoscopic cyclophotocoagulation (For extracapsular cataract removal without endoscopic cyclophotocoagulation, use 66984) (For complex extracapsular cataract removal with endoscopic cyclophotocoagulation, use 66987) (For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)	090	10.25

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66711 Tracking Number I1 Original Specialty Recommended RVU: **7.40**
Presented Recommended RVU: **7.35**
Global Period: 090 Current Work RVU: **7.93** RUC Recommended RVU: **6.36**

CPT Descriptor: Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old patient with a history of chronic glaucoma has progressive optic nerve damage and elevated intraocular pressure (IOP) that has not been controlled by medical therapy and a previous filtering operation. The patient is pseudo-phakic with a miotic pupil.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 35% , In the ASC 63%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications and pupillary dilation. Check adequacy of pupillary dilation. Perform a surgical time out. Administer sub-Tenon or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface. Check the settings of the photocoagulation unit and function of the light pipe.

Description of Intra-Service Work: Insert a lid speculum to allow adequate visualization. Make a multiplanar temporal clear corneal incision into the anterior chamber. Inject a small amount of viscoelastic into the anterior chamber, over the pupil and lens to protect the cornea. Then inject viscoelastic under the iris root for 180°. Use viscodissection to carefully separate the iris adhesions to the lens capsule and IOL, to facilitate visualization of the ciliary body processes with the endoscope. Insert the endoscope/laser probe through the temporal incision viewing the nasal ciliary processes on the heads-up display across the bed from the operating microscope. Reinject viscoelastic to those areas that need additional release of adhesions under direct visualization with the endoscope. While periodically viewing the position of the handpieces through the operating microscope, and continually having the OR staff manually adjusting and orienting the focus of the image on the endocyclophotocoagulation display from the lightpipe/endoscope laser probe, coagulate the ciliary processes through the endoscope.

Move the endoscope slowly in an arc of 180° allowing treatment of each individual ciliary process for several seconds with an endpoint of shrinkage and whitening. Reposition the probe to slowly apply a second row of cyclophotocoagulation to the portion of the pars plicata immediately inferior to the ciliary processes and remove the probe. Make a second multiplanar corneal incision 90° away from the first. Insert the endoscope/laser probe through this second incision and treat the contralateral ciliary processes and pars plicata to complete treatment of 270° of the processes. After completion of laser therapy, remove the viscoelastic material from the anterior segment of the eye with an irrigation and aspiration handpiece, with careful attention to remove viscoelastic trapped behind the iris. Confirm that the IOL remains in proper position. Remove the iris hooks one by one. Perform a peripheral iridectomy as necessary.

Inject a miotic drug into the anterior chamber to produce pupillary miosis as needed. Inject a corticosteroid drug into the anterior chamber and subconjunctival space. Reform the eye with balanced salt solution. Test the incisions for leaks. Suture

any incisions that leak. Remove the lid speculum. Place an antibiotic ointment on the eye as necessary. Place a soft patch and a rigid shield on the operative eye.

Description of Post-Service Work: Immediate post-service work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician.

Postoperative visits: Patient is seen for a level 2 visit on day 1 to check visual acuity, intraocular pressure, incision integrity, and level of inflammation. The patient is seen again for dilated level 3 visits approximately 1 week, 2 weeks, 1 month, and 6-8 weeks postoperatively to check visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019		
Presenter(s):	David B. Glasser, MD AAO, John T. McAllister, MD AAO, Parag Parekh, MD ASCRS		
Specialty Society(ies):	Ophthalmology		
CPT Code:	66711		
Sample Size:	1533	**Resp N:** 40	**Response:** 2.6 %
Description of Sample:	A random sample of members were pulled from the AAO, AGS and ASCRS databases.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.75	**10.00**	30.00	125.00
Survey RVW:	6.00	7.85	**9.01**	10.69	75.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**6.00**		
Intra-Service Time:	8.00	15.00	**20.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**108.00**	99211x **0.00** 12x **1.00** 13x **4.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	66711	**Recommended Physician Work RVU: 6.36**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**15.00**	**-9.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7B Local/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**21.00**	**-11.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**108.00**	99211x **0.00** 12x **1.00** 13x **4.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67210	090	6.36	**RUC Time**

CPT Descriptor Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66185	090	10.58	**RUC Time**

CPT Descriptor Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	2,132

CPT Descriptor 1 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
24076	090	7.41	**RUC Time**	843

CPT Descriptor 2 Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm

Other Reference CPT Code	Global	Work RVU	Time Source
67210	090	6.36	**RUC Time**

CPT Descriptor Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 40.0 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 15.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 66711	Top Key Reference CPT Code: 67210	2nd Key Reference CPT Code: **66185**
Median Pre-Service Time	34.00	17.00	25.00
Median Intra-Service Time	20.00	15.00	65.00
Median Immediate Post-service Time	10.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	0.00	19.00
Median Office Visit Time	108.0	69.00	140.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**191.00**	**106.00**	**259.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	12%	19%	50%	19%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	31%	62%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	6%	31%	62%
Physical effort required	0%	31%	69%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	19%	75%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	50%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	67%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	33%	50%	17%
Physical effort required	50%	17%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	100%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66711, *Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens* is being revalued as part of the family of endoscopic ciliary ablation codes associated with new CPT codes 66987 and 66988, which describe combined cataract surgery/endoscopic ciliary ablation procedures. The new codes were created because endoscopic ciliary ablation is performed over 75% of the time with cataract surgery. CPT 66711 was last reviewed by the RUC in 2004.

A random survey of American Academy of Ophthalmology, American Society of Cataract and Refractive Surgeons, and American Glaucoma Society members had 40 respondents, 90% of whom found the vignette to be typical. The median WRVU was 9.01 and the 25th percentile was 7.85. The median IST was 20 minutes. The survey showed four 99213 and one 99212 postoperative visits. The current work value of 66711 is 7.93 WRVU, with an IST of 30 minutes and the same number and level of postoperative visits.

The top key reference service, chosen by 40% of respondents, was CPT 67210, *Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation* (RUC 2010), with a WRVU of 6.36, an IST of 15 minutes, and three level 3 postoperative visits. The second reference service, chosen by 15% of respondents, was CPT 66185, *Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft* (RUC 2014), with a WRVU of 10.58, an IST of 65 minutes, three level 2 and four level 3 postoperative visits. The respondents ranked the surveyed code as more intense and complex on all intensity and complexity measures compared to the top key reference service.

The expert panel of the AAO, ASCRS, and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel agreed with the median IST of 20 minutes and the number and level of postoperative visits. A level 2 visit is done on the first postoperative day to check vision, pressure, incision integrity, and level of inflammation. Subsequent visits at 1, 2, 4, and 6-8 weeks are dilated level 3 visits. These patients typically have significant postoperative inflammation due to the ablation of the ciliary processes, necessitating frequent dilated examinations in the postoperative period to perform a detailed examination of the posterior retina for cystoid macular edema (CME). CME occurs more commonly in the presence of postoperative inflammation. The sooner CME is detected and treated, the lower the likelihood of permanent macular changes resulting in reduced visual acuity.

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are typically complex, difficult to operate eyes with a history of multiple prior procedures and miotic pupils. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 25 minutes, reduced the survey positioning time from 5 minutes to match the package time of 3 minutes, and reduced the package pre-service scrub, dress and wait time from 15 minutes to the survey time of 6 minutes. This is an increase in pre-time of 9 minutes compared to the current value. The extra time in the preoperative are is necessary for the physician to review the patient's prior surgical interventions, which are typically multiple, including cataract surgery and one or more prior failed glaucoma procedures. There are also more options available than there were in 2004, when the code was last valued, for supporting an intraocular lens that may be found to be loose or may be dislocated intraoperatively. In the past, these lenses were typically left alone if they covered the visual axis or removed if badly dislocated, but now they are supported with one of a variety of rings or sutures. While the need to use these devices intraoperatively is not typical, a discussion of and re-emphasis of prior office discussions regarding their potential use is typical in the preoperative area.

We used the survey post-service time median of 10 minutes, which is less than the 21 minutes of post-service time package 7B (local anesthesia, complex procedure) and unchanged from the current value, and one-half of a 99238 for discharge day management. Total time for the procedure is 191 minutes, with an IST of 20 minutes. Despite the 10-minute decrease in IST, the total time remains almost identical due to recognition of the increased time spent reviewing the complex past history and explaining the procedure in the pre-operative area.

As with CPT 66984 in this family, we were unable to find adequate crosswalk codes for the 25th percentile work value. In the absence of a crosswalk, we initially chose a work value recommendation of 7.40 WRVU, below the 25th percentile, based on matching the IWPUT to the current value. The reviewers were concerned with this atypical methodology and recommended pre-facilitation.

As a result of pre-facilitation, we are now recommending a crosswalk to the work value of the top key reference service, CPT 67210, *Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation* (RUC 2010), with 6.36 WRVU, an IST of 15 minutes, and total time of 106 minutes. While the IST

and total times don't match exactly, laser ablation of tissue is used in both CPT 67111 and our primary KRS, CPT 67210, making it a logical crosswalk from a clinical perspective. **Therefore, our recommended work value for CPT 66711 is 6.36 WRVU (IWPUT is 0.023), well below the survey's 25th percentile, with times of 34/20/10 minutes and a total time of 191 minutes.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) CPT 66711 is frequently billed in conjunction with 66982 or 66984, cataract surgery. New CPT codes have been established to capture the combined services, which should reduce the reporting of 66711 with other CPT codes.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4500
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Estimation Only

Specialty Opthalmology Frequency 4500 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,000
If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Ophthalmology Frequency 3000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 66711

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66982 Tracking Number I2 Original Specialty Recommended RVU: **11.08**
Presented Recommended RVU: **10.25**
Global Period: 090 Current Work RVU: **11.08** RUC Recommended RVU: **10.25**

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmentalstage; without endoscopic cyclophotocoagulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 71-year-old female presents with chronic angle closure glaucoma and posterior synechiae with fixed miotic pupil who has now developed a cataract. Cataract removal with IOL placement is recommended with iris hooks to open the small pupil.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 27% , In the ASC 72%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and family and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications and pupillary dilation. Perform a surgical time out. Administer topical, sub-Tenon or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface.

Description of Intra-Service Work: : Insert a lid speculum. Position the microscope. Make a side-port incision 45 to 90 degrees away from the intended site of the surgical incision. Fill the anterior chamber with a viscoelastic. Create a temporal multiplanar limbal/corneal incision into the anterior chamber. Make four additional 1-mm incisions at the limbus in order to place iris hooks in a diamond pattern around the eye. One by one, insert the iris hooks into the incisions and manipulate to retract the iris. Reposition the iris hooks in the areas of loose zonules to better support the iris and the capsule during subsequent steps of cataract removal.

Enter the eye through the main incision with a sharp bent needle to open the anterior capsule, followed by forceps to fashion a circular opening in the anterior capsule of the cataract. Insert a cannula into the eye to perform hydrodissection by injecting balanced salt solution between the lens cortex and capsule, loosening the nuclear and cortical layers of the lens in the process, while maintaining the integrity of the capsule. Hydrodelineate as needed by injecting balanced salt solution between the lens cortex and nucleus. Inject additional viscoelastic into the anterior chamber of the eye prior to phacoemulsification. Check the function of the phacoemulsification handpiece and the machine settings. Remove bubbles by tapping the handpiece with irrigation on. Insert the phacoemulsification tip into the eye and a second instrument through the side port incision.

Using both hands as well as the foot actuated phaco pedal, carefully perform phacoemulsification with simultaneous aspiration of the lens nuclear material. Rotate and dis-assemble the lens to avoid inadvertent trauma to the cornea, lens capsule or iris. Add viscoelastic as needed to maintain a safe working space. Remove the phacoemulsification tip and the second instrument from the eye once all of the nuclear material has been removed. Introduce an irrigation and aspiration tip

into the eye to aspirate the remainder of the cortical lens material. Then carefully vacuum and polish the interior surface of the thin lens capsule in an attempt to avoid future secondary membrane formation.

Assess the integrity of the capsule and zonules and determine how much additional support the capsular bag and intraocular lens (IOL) will require. Enlarge incisions and create scleral flaps as needed for the IOL and support system chosen. Insert and suture a capsular tension ring or segment as needed. While maintaining traction on the eye via the side port incision, insert the tip of the IOL injection device into the main incision and place the IOL in the eye. Once in the eye, allow the IOL to unfold without damage to the cornea. Properly position and center the IOL using a lens hook. Suture the IOL and/or capsular bag/zonular complex as needed. Remove the viscoelastic material from the anterior segment of the eye with an irrigation and aspiration handpiece. Remove the iris hooks one by one. Perform a peripheral iridectomy as necessary.

Inject a miotic drug into the anterior chamber to produce pupillary miosis as needed. Reform the eye with balanced salt solution and adjust the intraocular pressure to a physiologic range. Test the incisions for leaks. Suture any incisions that leak. Remove the lid speculum. Place an antibiotic ointment on the eye as necessary. Place a soft patch and a rigid shield on the operative eye.

Description of Post-Service Work: Immediate post-service work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician.

Postoperative visits: Patient is seen for a level 2 visit on day 1 to check visual acuity, intraocular pressure, incision integrity, and level of inflammation. The patient is seen again for dilated level 3 visits approximately 1 week, 2-4 weeks, and 6-8 weeks postoperatively to check visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema and peripheral retina for tears or detachments.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019		
Presenter(s):	David B. Glasser, MD AAO, John T. McAllister, MD AAO, Parag Parekh, MD ASCRS		
Specialty Society(ies):	Ophthalmology		
CPT Code:	66982		
Sample Size:	1541	**Resp N:** 92	**Response:** 5.9 %
Description of Sample:	A random sample of members were pulled from the AAO, AGS and ASCRS databases.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	22.00	**40.00**	80.00	230.00
Survey RVW:	7.00	11.50	**12.89**	14.21	25.10
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**7.00**		
Intra-Service Time:	10.00	20.00	**30.00**	36.25	60.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**92.00**	99211x **0.00** 12x **0.00** 13x **4.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	66982	**Recommended Physician Work RVU: 10.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**7.00**	**15.00**	**-8.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7B Local/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**6.00**	**21.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**85.00**	99211x **0.00** 12x **1.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
67036	090	12.13	**RUC Time**

CPT Descriptor Vitrectomy, mechanical, pars plana approach;

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65850	090	11.39	**RUC Time**

CPT Descriptor Trabeculotomy ab externo

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54437	090	11.50	**RUC Time**	51

CPT Descriptor 1 Repair of traumatic corporeal tear(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
53850	090	10.08	**RUC Time**	4,253

CPT Descriptor 2 Transurethral destruction of prostate tissue; by microwave thermotherapy

Other Reference CPT Code	Global	Work RVU	Time Source
67110	090	10.25	**RUC Time**

CPT Descriptor Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)n

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 **% of respondents:** 20.6 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 19.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 66982	Top Key Reference CPT Code: 67036	2nd Key Reference CPT Code: **65850**
Median Pre-Service Time	35.00	51.00	37.50
Median Intra-Service Time	30.00	50.00	60.00
Median Immediate Post-service Time	6.00	15.00	17.50
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	38.00
Median Office Visit Time	85.0	115.00	80.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**175.00**	**250.00**	**233.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	21%	47%	32%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	21%	53%	26%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	74%	26%
Physical effort required	5%	69%	26%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and	0%	53%	47%

judgment of physician • Estimated risk of malpractice suit with poor outcome	

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	28%	33%	28%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	33%	39%	28%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	28%	61%
Physical effort required	11%	61%	28%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	39%	39%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66982, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation* is being revalued as part of the family of cataract surgery codes associated with new CPT codes 66987 and 66988, which describe combined cataract surgery/endoscopic ciliary ablation procedures. The new codes were created because endoscopic ciliary ablation is performed over 75% of the time with cataract surgery. CPT 66982 was last valued by the RUC in 2012.

A random survey of American Academy of Ophthalmology, American Society of Cataract and Refractive Surgeons, and American Glaucoma Society members had 92 respondents, 91% of whom found the vignette to be typical. The median WRVU was 12.89 and the 25th percentile was 11.50. The median IST was 30 minutes. The survey showed four 99213 postoperative visits. The current work value of 66982 is 11.08 WRVU, with an IST of 33 minutes, two level 2 and two level 3 postoperative visits.

The expert panel of the AAO, ASCRS, and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The key reference service comparisons proved problematic as only 21% of respondents chose the primary reference service, CPT 67036, *Vitrectomy, mechanical, pars plana approach* (RUC 2013), with a WRVU of 12.13, an IST of 50 minutes, and five level 3 postoperative visits. Only 20% of respondents chose CPT 65850, *Trabeculotomy ab externo* (RUC 2005), with 11.39 WRVU, an IST of 60 minutes, and five level 2 postoperative visits as a reference service. While respondents who ranked the intensity and complexity of the reference codes similar to that of the surveyed code, an almost equal number (17%) chose CPT 66179 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (RUC 2015), with 14.00 WRVU, an IST of 55 minutes, and 8 postoperative visits. Respondents ranked CPT 66179, which has a similar IWPUT as the top 2 reference codes, as lower in intensity and complexity than the surveyed code. As with the survey for CPT 66984, the panel believes that the low percentage of respondents who chose each reference service reflect the dissimilarity between cataract surgery and other intraocular procedures, and that respondents picked reference codes based primarily on similarity to their chosen work value estimates. That they ranked CPT 66982 as more intense than CPT 66179 (aqueous shunt, IWPUT 0.1156) but similar in intensity to CPT 67036 (vitrectomy, IWPUT 0.108) and CPT 65850 (trabeculectomy, IWPUT 0.111) highlights the inconsistency between the intensity/complexity metrics and the actual intensities of the reference codes, making it problematic to use the key reference services to compare complexity in this survey.

The panel agreed with the median IST of 30 minutes and the survey findings of four postoperative visits. However, the panel felt that rather than four 99213 visits as supported by the survey, the first postoperative visit should be a level 2, which is typical of the work associated with an undilated examination to check vision, pressure, incision integrity, and inflammation. The subsequent postoperative visits at 1 week, 2-4 weeks, and 6-8 weeks are all dilated level 3 visits to assess IOL position and presence of macular edema and peripheral retinal tears or detachments in addition to the portions of the exam that can be performed without dilation (checking vision, intraocular pressure, and status of the anterior segment of the eye). The Academy's Preferred Practice Pattern recommends dilated examinations in the postoperative period, specifically to assess for macular edema. The largest professional liability insurer of ophthalmologists (OMIC) emphasizes the importance of dilated examinations to their insureds because in their claims database, the most common missed diagnosis leading to claims is retinal detachment due to failure to perform a dilated examination. An additional visit compared to CPT 66984 is necessary in these patients with more complex eyes and greater degrees of inflammation and risk of lens implant dislocation and retinal disease. The increase in one of the postoperative visits from level 2 to level 3 compared to the current value of the code is also supported by the survey and is consistent with the typical postoperative course.

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are complex cases with multiple potential variants of the procedure that may be necessary as the procedure develops, and these need to be re-reviewed by the surgeon and discussed with the patient immediately prior to surgery in the preoperative area. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 25 minutes, reduced the survey positioning time from 5 minutes to match the package time of 3 minutes, and reduced the package pre-service scrub, dress and wait time from 15 minutes to the survey time of 7 minutes. This represents a 10-minute increase in pre-service time compared to the current value of the code, and is necessary because of the increased number of options for lens fixation that may arise during surgery and the need to discuss their potential effect on planned visual outcome. We used the survey post-service time median of 6 minutes, which is less than the 21 minutes of post-service time package 7B (local anesthesia, complex procedure) and a 4-minute decrease compared to the current value, and one-half of a 99238 for discharge day management. Total time for the procedure is 175 minutes, with an IST of 30 minutes.

Despite the 3-minute decrease in IST and 10-minute increase in total time, the panel felt that the overall work of the procedure was unchanged, and initially recommended maintaining the work value at 11.04 WRVU. The expert panel believes that cataract surgery has not decreased in intensity since last valued. It is almost entirely an intraocular procedure. Nearly all of the 30 minutes of IST is spent working inside the eye, where a miniscule error can result in a ruptured capsule with a dropped nucleus, leading to an increased risk of serious complications such as endophthalmitis or retinal detachment with permanent loss of vision. The lens capsule is less than 5 microns thick posteriorly. That thin, mobile membrane serves as the only barrier between an uncomplicated case and a complicated one. While those complications are uncommon, they are always only a few microns away and contribute to the technical skill requirements and intensity of the intraservice work. Cataract surgery has not become any less intense over the years and remains intense throughout the course of the procedure. If anything, the intensity of the work has increased over time as patient expectations for "perfect vision" after cataract surgery have become typical. However, there are no crosswalks to support this work value because of its high intensity. Further, the low number of respondents choosing each reference service and the inconsistency of their intensity rankings made use of the KRS problematic. The reviewers were concerned with these issues, and for that reason we sought pre-facilitation.

As a result of pre-facilitation, we have chosen a crosswalk to CPT 67110, *Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)* (RUC 2015), with 10.25 WRVU, 30 minutes IST and 196 minutes total time. Although somewhat shorter in total time due to fewer postoperative visits, the intraservice portion of CPT 66982 is of greater intensity than CPT 67110, making for a reasonable work value crosswalk. **We recommend a work value of 10.25 WRVU for CPT 66982, below the survey's 25th percentile value, crosswalked to CPT 67110, and with times of 35/30/6 and a total time of 175 minutes.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 245175
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimation only

Specialty Ophthalmology Frequency 245175 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 163,451 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty Ophthalmology Frequency 163451 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Cataract removal/lens insertion

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 66982

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66987 Tracking Number I3 Original Specialty Recommended RVU: **13.50**
Presented Recommended RVU: **13.15**
Global Period: 090 Current Work RVU: **N/A** RUC Recommended RVU: **13.15**

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old female with a history of visually significant cataract and chronic glaucoma and that is not controlled by current therapy. Combined cataract removal, intraocular lens implantation, and treatment of the ciliary processes with endoscopic cyclophotocoagulation to reduce aqueous production is recommended. Iris hooks are needed to open the small pupil.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 23% , In the ASC 77%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications and pupillary dilation. Check adequacy of pupillary dilation. Perform a surgical time out. Administer sub-Tenon or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface. Check the settings of the photocoagulation unit and function of the light pipe.

Description of Intra-Service Work: Insert a lid speculum. Make a side-port incision remote from the anticipated surgical incision. Fill the anterior chamber with a viscoelastic. Create a temporal multiplanar limbal/corneal incision into the anterior chamber. Make four additional 1-mm incisions at the limbus in order to place iris hooks in a diamond pattern around the eye. One by one, insert the iris hooks into the incisions and manipulate to retract the iris. Reposition the iris hooks in the areas of loose zonules to better support the iris and the capsule during subsequent steps of cataract removal.

Use sharp bent needle and forceps to fashion an opening in the anterior capsule of the cataract. Perform hydrodissection by injecting fluid between the lens cortex and capsule, loosening the lens in the process. Hydrodelineate as needed by injecting fluid between the lens cortex and nucleus. Inject additional viscoelastic into the anterior chamber prior to phacoemulsification. Check the function of the phacoemulsification handpiece and the machine settings. Remove bubbles by tapping the handpiece with irrigation on. Insert the phacoemulsification tip into the eye. Perform phacoemulsification with simultaneous aspiration of the lens nuclear material. Rotate and dis-assemble the lens to avoid inadvertent trauma to the cornea, lens capsule or iris. Use the side-port incision to allow access for a second instrument to aid in the disassembly process. Remove the phacoemulsification tip from the eye once all of the nuclear material has been removed. Introduce an irrigation-aspiration tip into the eye to aspirate the remainder of the cortical lens material. Then carefully vacuum and polish the thin posterior lens capsule in an attempt to avoid future secondary membrane formation.

Assess the integrity of the capsule and zonules and determine how much additional support the capsular bag and intraocular lens (IOL) will require. Enlarge incisions and create scleral flaps as needed for the IOL and support system chosen. Insert

and suture a capsular tension ring or segment as needed. Place the IOL in the eye using an injection device. Once in the eye, position and center the lens properly using a lens hook. Suture the IOL and/or capsular bag/zonular complex as needed.

Re-inject a small amount of viscoelastic into the anterior chamber, over the pupil and lens to protect the cornea. Then inject viscoelastic under the iris root for 180° to facilitate visualization of the ciliary body processes with the endoscope. Insert the endoscope/laser probe through the temporal incision viewing the nasal ciliary processes on the heads-up display across the bed from the operating microscope. While periodically viewing the position of the handpieces through the operating microscope, and continually having the OR staff manually adjusting and orienting the focus of the image on the endocyclophotocoagulation display from the lightpipe probe, coagulate the ciliary processes through the endoscope with the endpoint of shrinkage and whitening. Move the endoscope slowly in an arc allowing treatment of each individual process over an arc of 180° and remove the probe. Make a second corneal incision 90° away from the first or enlarge the prior side-port incision if it is properly positioned. Insert the endoscope/laser probe through this second incision and treat the contralateral ciliary processes to complete treatment of 270° to 360° of the processes. After completion of laser therapy, remove the viscoelastic material from the anterior segment of the eye with an irrigation and aspiration handpiece, with careful attention to remove viscoelastic trapped behind the iris. Confirm that the IOL remains in the proper position. Remove the iris hooks one by one. Perform a peripheral iridectomy as necessary.

Inject a miotic drug into the anterior chamber to produce pupillary miosis as needed. Inject a corticosteroid drug into the anterior chamber. Reform the eye with balanced salt solution. Test the incisions for leaks. Suture any incisions that leak. Remove the lid speculum. Place an antibiotic ointment on the eye as necessary. Place a soft patch and a rigid shield on the operative eye.

Description of Post-Service Work: Immediate post-service work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician.

Postoperative visits: Patient is seen for a level 2 visit on day 1 to check visual acuity, intraocular pressure, incision integrity, and level of inflammation. The patient is seen again for dilated level 3 visits approximately 1, 2, 3-4, 6-8, and 10-12 weeks postoperatively to check visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema and peripheral retina for tears or detachments.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019		
Presenter(s):	David B. Glasser, MD AAO, John T. McAllister, MD AAO, Parag Parekh MD ASCRS		
Specialty Society(ies):	Ophthalmology		
CPT Code:	66987		
Sample Size:	1534	**Resp N:** 31	**Response:** 2.0 %
Description of Sample:	A random sample of members were pulled from the AAO, AGS and ASCRS databases.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.50	**19.00**	32.50	400.00
Survey RVW:	8.88	13.50	**14.88**	16.22	34.36
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	20.00	30.00	**36.00**	47.50	90.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**131.00**	99211x **0.00** 12x **1.00** 13x **5.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	66987	**Recommended Physician Work RVU: 13.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**33.00**	**-3.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**36.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7B Local/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**21.00**	**-11.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**131.00**	99211x **0.00** 12x **1.00** 13x **5.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66179	090	14.00	**RUC Time**

CPT Descriptor Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65285	090	15.36	**RUC Time**

CPT Descriptor Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
53440	090	13.36	**RUC Time**	930

CPT Descriptor 1 Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52601	090	13.16	**RUC Time**	46,069

CPT Descriptor 2 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

Other Reference CPT Code	Global	Work RVU	Time Source
15115	090	11.28	**RUC Time**

CPT Descriptor Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 32.2 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 25.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 66987	Top Key Reference CPT Code: 66179	2nd Key Reference CPT Code: **65285**
Median Pre-Service Time	43.00	25.00	60.00
Median Intra-Service Time	36.00	55.00	90.00
Median Immediate Post-service Time	10.00	10.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	131.0	163.00	154.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**239.00**	**272.00**	**353.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	10%	20%	60%	10%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	30%	70%
Physical effort required	10%	40%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	40%	60%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	25%	38%	37%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	13%	87%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	25%	75%
Physical effort required	0%	13%	87%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	13%	87%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66987, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation body destruction* is a new CPT code combining

complex cataract surgery and IOL surgery with endoscopic ciliary ablation for glaucoma because the latter procedure is performed over 75% of the time with cataract surgery. This procedure was previously reported with CPT 66982 and CPT 66711, and subject to the multiple procedure payment reduction.

A random survey of American Academy of Ophthalmology, American Society of Cataract and Refractive Surgeons, and American Glaucoma Society members had 31 respondents, 97% of whom found the vignette to be typical. The median WRVU was 14.88 and the 25th percentile was 13.50. The median IST was 36 minutes. The survey showed five 99213 and one 99212 postoperative visits.

The top key reference service, chosen by 32% of respondents, was CPT 66179, *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (RUC 2014), with a WRVU of 14.00, an IST of 55 minutes, and five level 3 and three level 2 postoperative visits. The second reference service, chosen by 26% of respondents, was CPT 65285, *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* (RUC 2011), with a WRVU of 15.36, an IST of 90 minutes, and six level 3 and one level 2 postoperative visits. The respondents ranked the surveyed code as more intense and complex on all intensity and complexity measures compared to both key reference services.

The expert panel of the AAO, ASCRS, and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel agreed with the median IST of 36 minutes and the number and level of postoperative visits. A level 2 visit is done on the first postoperative day to check vision, pressure, incision integrity, and level of inflammation. These patients typically have significantly greater than normal postoperative inflammation and unstable IOP due to the combined nature of the procedure with ciliary body ablation, as well as the potential for IOL dislocation, necessitating more frequent dilated examinations in the postoperative period than the standalone cataract (CPT 66982) or endocyclophotocoagulation (CPT 66711) procedures. Dilated level 3 examinations are typical at 1, 2, 3-4, 6-8, and 10-12 weeks postoperatively because of the need for detailed examination of the posterior retina for macular edema, the peripheral retina for tears or detachments, and the peripheral intraocular lens implant for decentration and stability.

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are typically complex, difficult to operate eyes with miotic pupils. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 30 minutes, which is necessary to review the history and explain the multiple surgical options that may be taken during the procedure. We reduced the survey positioning time from 5 minutes to match the package time of 3 minutes, and reduced the package pre-service scrub, dress and wait time from 15 minutes to the survey time of 10 minutes. As with the standalone complex cataract procedure (CPT 66982), there are an increased number of options for lens fixation that may arise during surgery which must be reviewed by the physician and discussed with the patient to explain their potential effect on the expected length of the procedure and planned visual outcome. These patients also typically require a greater wait time after the anesthetic injection than cataract surgery or ciliary ablation cases done alone because the combined cases take longer and involve direct cauterization of sensitive uveal tissue, so longer acting drugs which take longer to take effect (e.g. bupivacaine) are typically employed. The physician typically does a personal check of the settings and function of the photocoagulation unit, monitor and light pipe prior to the incision. We used the survey post-service time median of 10 minutes, which is less than the 21 minutes of post-service time package 7B (local anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 239 minutes, with an IST of 36 minutes.

We were unable to find a high-quality crosswalk for the survey's 25th percentile work value of 13.50 WRVU. After pre-facilitation of the other codes in this family, we determined that a building block type method, based on the adding the difference in work value between CPT 66984 and CPT 66988 to the work value of CPT 66982, would most fairly and appropriately value 66987. The recommended work value of CPT 66984 is 7.35 WRVU and CPT 66988 is 10.25 WRVU. The difference of 2.90 WRVU represents the work of the added ciliary photoablation portion of the procedure. Adding this work value to the recommended value for complex cataract surgery alone (CPT 66982) yields a combined procedure work value of 13.15, slightly below the survey's 25th percentile. **We recommend a work value of 13.15 WRVU for CPT 66987, with times of 43/36/10 and a total time of 239 minutes.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimation Only

Specialty Ophthalmology Frequency 1500 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimation Only

Specialty Ophthalmology Frequency 1000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Cataract removal/lens insertion

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 66982

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66984 Tracking Number I5 Original Specialty Recommended RVU: **8.04**
Presented Recommended RVU: **7.41**
Global Period: 090 Current Work RVU: **8.52** RUC Recommended RVU: **7.35**

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female complains of vision problems. Examination reveals that a cataract in her right eye has progressed to the point of visual impairment. She has difficulty reading and recently failed a driving test.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 24% , In the ASC 73%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 96% , Overnight stay-less than 24 hours 4% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications and pupillary dilation. Check adequacy of pupillary dilation. Perform a surgical time out. Administer topical, sub-Tenon or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface.

Description of Intra-Service Work: : Insert a lid speculum. Position the microscope. Make a side-port incision 45 to 90 degrees away from the intended site of the surgical incision. Fill the anterior chamber with a viscoelastic. Create a temporal multiplanar limbal/corneal incision into the anterior chamber. Enter the eye through the main incision with a sharp bent needle to open the anterior capsule, followed by forceps to fashion a circular opening in the anterior capsule of the cataract. Insert a cannula into the eye to perform hydrodissection by injecting balanced salt solution between the lens cortex and capsule, loosening the nuclear and cortical layers of the lens in the process, while maintaining the integrity of the capsule. Hydrodelineate as needed by injecting fluid between the lens cortex and nucleus. Inject additional viscoelastic into the anterior chamber prior to phacoemulsification. Check the function of the phacoemulsification handpiece and the machine settings. Remove bubbles by tapping the handpiece with irrigation on. Insert the phacoemulsification tip into the eye and a second instrument through the side port incision. Using both hands and the foot actuated phaco pedal, carefully perform phacoemulsification with simultaneous aspiration of the lens nuclear material. Rotate and dis-assemble the lens to avoid inadvertent trauma to the cornea, lens capsule or iris. Add viscoelastic as needed to maintain a safe working space. Remove the phacoemulsification tip and second instrument from the eye. Introduce an irrigation and aspiration tip into the eye to aspirate the remainder of the cortical lens material. Then carefully vacuum and polish the interior surface of the thin lens capsule in an attempt to avoid future secondary membrane formation.

Adjust the size of the incision as needed to accommodate the intraocular lens (IOL). While maintaining traction on the eye via the side port incision, insert the tip of the IOL injection device into the main incision and place the IOL in the eye. Once in the eye, allow the IOL unfold without damage to the cornea. Properly position and center the IOL into the capsular bag using a lens hook.
Remove the viscoelastic material from the anterior segment of the eye with an irrigation and aspiration handpiece. Inject a miotic drug into the anterior chamber to produce pupillary miosis as needed. Reform the eye with balanced salt solution and adjust the intraocular pressure to a physiologic range. Test the incisions for leaks. Suture any incisions that leak.

Remove the lid speculum. Place an antibiotic ointment on the eye as necessary. Place a soft patch and a rigid shield on the operative eye.

Description of Post-Service Work: Immediate post-service work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician.

Postoperative visits: Patient is seen for a level 2 visit on day 1 to check visual acuity, intraocular pressure, incision integrity, and level of inflammation. The patient is seen again for dilated level 3 visits approximately 1 week and 1 month postoperatively to check visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema and peripheral retina for tears or detachments.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019		
Presenter(s):	David Glasser, MD AAO, John McAllister, MD AAO and Parag Parekh, MD, ASCRS		
Specialty Society(ies):	Ophthalmology7		
CPT Code:	66984		
Sample Size:	1540	**Resp N:** 93	**Response:** 6.0 %
Description of Sample:	A random sample of members were pulle3d from the AAO, AGS and ASCRS databases.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	175.00	**300.00**	500.00	2100.00
Survey RVW:	5.00	10.10	**11.39**	12.40	22.00
Pre-Service Evaluation Time:			**24.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**6.00**		
Intra-Service Time:	9.00	15.00	**20.00**	23.00	60.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	66984	**Recommended Physician Work RVU: 7.35**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**6.00**	**6.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**18.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65850	090	11.39	**RUC Time**

CPT Descriptor Trabeculotomy ab externo

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66184	090	9.58	**RUC Time**

CPT Descriptor Revision of aqueous shunt

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54530	090	8.46	**RUC Time**	1,231

CPT Descriptor 1 Orchiectomy, radical, for tumor; inguinal approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,280

CPT Descriptor 2 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

Other Reference CPT Code	Global	Work RVU	Time Source
67210	090	6.36	**RUC Time**

CPT Descriptor Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 **% of respondents:** 20.4 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 19.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 66984	Top Key Reference CPT Code: 65850	2nd Key Reference CPT Code: **66184**
Median Pre-Service Time	20.00	37.50	25.00
Median Intra-Service Time	20.00	60.00	60.00
Median Immediate Post-service Time	5.00	17.50	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	38.00	19.00
Median Office Visit Time	62.0	80.00	140.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**126.00**	**233.00**	**254.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	26%	37%	37%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	26%	53%	21%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	16%	32%	52%
Physical effort required	16%	63%	21%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and	32%	37%	31%

judgment of physician • Estimated risk of malpractice suit with poor outcome	

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	28%	45%	22%	5%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	55%	33%	11%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	28%	55%
Physical effort required	50%	33%	16%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	39%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66984, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), without endoscopic cyclophotocoagulation* is being revalued as part of the family of cataract surgery codes associated with new

CPT codes 66X01 and 66X02, which describe combined cataract surgery/endoscopic ciliary ablation procedures. The new codes were created because endoscopic ciliary ablation is performed over 75% of the time with cataract surgery. CPT 66984 was last valued by the RUC in 2012.

A random survey of American Academy of Ophthalmology, American Society of Cataract and Refractive Surgeons, and American Glaucoma Society members had 93 respondents, 99% of whom found the vignette to be typical. The median WRVU was 11.39 and the 25th percentile was 10.10. The median IST was 20 minutes.

The survey showed three 99213 postoperative visits. The current work value of 66984 is 8.52 WRVU, with an IST of 21 minutes, two level 2 and two level 3 postoperative visits.

The expert panel of the AAO, ASCRS, and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The key reference service comparisons proved problematic as only 20% chose the primary reference service, CPT 65850, *Trabeculotomy ab externo* (RUC 2005), with a WRVU of 11.39, an IST of 60 minutes, and five level 2 postoperative visits. Only 19% of respondents chose CPT 66184, *Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft* (RUC 2014), with 9.58 WRVU, 60 minutes IST, and 3 level 2 and 4 level 3 postop visits as a reference service. While respondents who ranked the intensity and complexity of the reference codes similar to that of the surveyed code, those who chose CPT 67210, *Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation* (RUC 2010) as a reference ranked the surveyed code higher or much higher in intensity than the surveyed code. The wide distribution of choices among the RSL reflects the dissimilarity between cataract surgery and other intraocular procedures. The panel believes that the most popular RSL choices were made by respondents because their work values are close to the work values they selected by magnitude estimation for the surveyed code. The fact that respondents ranked CPT 66984 as more intense than CPT 67210 (IWPUT 0.199) but equal in intensity to CPT 65850 (IWPUT 0.111) and CPT 66184 (IWPUT 0.048) highlights the inconsistency between the intensity/complexity metrics and the actual intensities of the reference codes, making it problematic to use the key reference services to compare complexity in this survey.

The panel agreed with the survey median IST of 20 minutes (almost identical to the current value of 21 minutes) and the survey findings of three postoperative visits (one less than the current value). However, the panel felt that rather than three 99213 visits as supported by the survey, one 99212 and two 99213 visits more accurately reflected the work done in the postoperative period, with the level 2 visit representing the work associated with the typical one-day postop visit and the level 3 visits typical of the dilated exam performed at the second and final postop examinations. The subsequent examinations at approximately one week and one month need to include dilation to assess the macula in detail for presence of macular edema and the peripheral retina for tears or detachments. The Academy's Preferred Practice Pattern recommends dilated examinations in the postoperative period, specifically to assess for macular edema. The largest professional liability insurer of ophthalmologists (OMIC) emphasizes the importance of dilated examinations to their insureds because in their claims database, the most common missed diagnosis leading to claims is retinal detachment due to failure to perform a dilated examination

We chose pre-service package 1 (straightforward patient, straightforward procedure) with a total of 20 minutes, which is less than the survey median pre-service time of 35 minutes and 2 minutes less than the current pre-service time. We used the survey post-service time median of 5 minutes, which is less than the 18 minutes of post-service time package 7A (local anesthesia, straightforward procedure) and 2 minutes less than the current post-service time, and one-half of a 99238 for discharge day management. Total time for the procedure is 126 minutes, with an IST of 20 minutes.

We initially recommended a work value of 8.04, arrived at by a reverse building block method to subtract the work value of one less level 2 postoperative visit, as this is the only substantive change since the code was last surveyed.

As with CPT 66982, there are no crosswalks to support this work value because of its high intensity. As noted above, use of the KRS to support the intensity was problematic due to the low number choosing each reference service and the inconsistency of the intensity rankings. Nevertheless, respondents chose work values and times at a much higher IWPUT than the codes on the RSL. The expert panel believes that cataract surgery has not decreased in intensity since last valued. It is almost entirely an intraocular procedure. Nearly all of the 20 minutes of IST is spent working inside the eye, where a miniscule error can result in a ruptured capsule with a dropped nucleus, leading to an increased risk of serious complications such as endophthalmitis or retinal detachment with permanent loss of vision. The lens capsule is less than 5 microns thick posteriorly. That thin, mobile membrane serves as the only barrier between an uncomplicated case and a complicated one. While those complications are uncommon, they are always only a few microns away and contribute to the

technical skill requirements and intensity of the intraservice work. Cataract surgery has not become any less intense over the years and remains intense throughout the course of the procedure. If anything, the intensity of the work has increased over time as patient expectations for "perfect vision" after cataract surgery have become typical.

While there have been examples of the RUC using reverse building block in the past (CPT 52341-52346, cystoscopy, where hospital visit values were removed with a change in site of service in 2008), the reviewers for this code were uncomfortable with that methodology. We therefore sought pre-facilitation meeting to discuss the valuation methodology.

As a result of pre-facilitation, we have chosen to use a crosswalk to CPT 67210, *Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation* (RUC 2010), which has 6.36 WRVU, a 15-minute IST, a total time of 106 minutes, and an IWPUT of 0.199. While a minority of those surveyed chose CPT 67210 as a reference code, those that did choose it ranked the intensity and complexity of the cataract code as greater or much greater. As an intraocular procedure, CPT 66984 is more intense than CPT 67210, which is an extraocular laser procedure.

The surveyed IST for CPT 66984 is 5 minutes longer than the IST of CPT 67210. By taking the 5-minute increment in IST and multiplying it by the current IWPUT of CPT 66984 at the time it was surveyed (0.210), we calculated a recommended work value for CPT 66984 that is 1.05 WRVU greater than the work value of CPT 67210, or 7.41 WRVU. **Therefore, our recommended work value for 66984 is 7.41 WRVU, well below the survey's 25th percentile, with times of 20/20/5 minutes and a total time of 126 minutes.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2,618,000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimation only

Specialty Ophthalmology Frequency 2618000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,745,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimation based on RUC database

Specialty Ophthalmology Frequency 1745000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Cataract removal/lens insertion

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 66984

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:66988 Tracking Number I6 Original Specialty Recommended RVU: **11.08**
Presented Recommended RVU: **10.25**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **10.25**

CPT Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male with a history of visually significant cataract and chronic glaucoma and that is not controlled by current therapy. Combined cataract removal, intraocular lens implantation and treatment of the ciliary processes to reduce aqueous production is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 26% , In the ASC 74%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record and preoperative diagnostic testing. Discuss the planned procedure with the patient and obtain informed consent. Identify and mark the eye for surgery. Write preoperative orders for medications and pupillary dilation. Check adequacy of pupillary dilation. Perform a surgical time out. Administer sub-Tenon or retrobulbar anesthetic. Reposition the patient. Prep and drape the ocular surface. Check the settings of the photocoagulation unit and function of the light pipe.

Description of Intra-Service Work: Insert a lid speculum. Position the microscope. Make a side-port incision away from the intended site of the surgical incision. Fill the anterior chamber with a viscoelastic. Create a temporal multiplanar limbal/corneal incision into the anterior chamber. Use sharp bent needle and forceps to fashion an opening in the anterior capsule of the cataract. Perform hydrodissection by injecting fluid between the lens cortex and capsule, loosening the lens in the process. Hydrodelineate as needed by injecting fluid between the lens cortex and nucleus. Inject additional viscoelastic into the anterior chamber prior to phacoemulsification. Check the function of the phacoemulsification handpiece and the machine settings. Remove bubbles by tapping the handpiece with irrigation on. Insert the phacoemulsification tip into the eye. Perform phacoemulsification with simultaneous aspiration of the lens nuclear material. Rotate and dis-assemble the lens to avoid inadvertent trauma to the cornea, lens capsule or iris. Use the side-port incision to allow access for a second instrument to aid in the disassembly process. Remove the phacoemulsification tip from the eye. Introduce an irrigation-aspiration tip into the eye to aspirate the remainder of the cortical lens material. Then carefully vacuum and polish the thin posterior lens capsule in an attempt to avoid future secondary membrane formation.

Adjust the size of the incision as needed to accommodate the intraocular lens (IOL). Place the IOL in the eye using an injection device. Once in the eye, properly position and center the IOL using a lens hook.

Re-inject a small amount of viscoelastic into the anterior chamber, over the pupil and lens to protect the cornea. Then inject viscoelastic under the iris root for 180° to facilitate visualization of the ciliary body processes with the endoscope. Insert the endoscope/laser probe through the temporal incision viewing the nasal ciliary processes on the heads-up display across the bed from the operating microscope. While periodically viewing the position of the handpieces through the operating microscope, and continually having the OR staff manually adjusting and orienting the focus of the image on the endocyclophotocoagulation display from the lightpipe probe, coagulate the ciliary processes through the endoscope with

the endpoint of shrinkage and whitening. Move the endoscope slowly in an arc allowing treatment of each individual process over an arc of 180° and remove the probe. Make a second corneal incision 90° away from the first or enlarge the prior side-port incision if it is properly positioned. Insert the endoscope/laser probe through this second incision and treat the contralateral ciliary processes to complete treatment of 270° to 360° of the processes. After completion of laser therapy, remove the viscoelastic material from the anterior segment of the eye with an irrigation and aspiration handpiece, with careful attention to remove viscoelastic trapped behind the iris. Confirm that the IOL remains in the proper position. Remove the iris hooks one by one. Perform a peripheral iridectomy as necessary.

Inject a miotic drug into the anterior chamber to produce pupillary miosis as needed. Inject a corticosteroid drug into the anterior chamber. Reform the eye with balanced salt solution. Test the incisions for leaks. Suture any incisions that leak. Remove the lid speculum. Place an antibiotic ointment on the eye as necessary. Place a soft patch and a rigid shield on the operative eye.

Description of Post-Service Work: Immediate post-service work: Write post-operative orders and prescriptions for post-operative medications. Complete an operative report. Discuss the surgical procedure and post op instructions with the patient and family. Necessary follow up testing and exams as well as medications, activity and restrictions are reviewed. Communicate with the referring physician.

Postoperative visits: Patient is seen for a level 2 visit on day 1 to check visual acuity, intraocular pressure, incision integrity, and level of inflammation. The patient is seen again for dilated level 3 visits approximately 1, 2, 4, and 6-8 weeks postoperatively to check visual acuity, intraocular pressure, incision integrity, corneal clarity, level of inflammation, and detailed examination of the central retina for cystoid macular edema and peripheral retina for tears or detachments.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019		
Presenter(s):	David B. Glasser, MD AAO, John T. McAllister, MD AAO, Parag Parekh, MD ASCRS		
Specialty Society(ies):	Ophthalmology		
CPT Code:	66988		
Sample Size:	1535	**Resp N:** 31	**Response:** 2.0 %
Description of Sample:	A random sample of members were pulled from the AAO, AGS and ASCRS databases.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	7.50	**25.00**	50.00	400.00
Survey RVW:	7.30	11.08	**13.95**	14.93	28.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	12.00	25.00	**30.00**	40.00	100.00

Immediate Post Service-Time:	**7.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**115.00**	99211x **0.00** 12x **0.00** 13x **5.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	66988	**Recommended Physician Work RVU: 10.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**33.00**	**-8.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7B Local/Complex Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**7.00**	**21.00**	**-14.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**108.00**	99211x **0.00** 12x **1.00** 13x **4.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66179	090	14.00	**RUC Time**

CPT Descriptor Aqueous shunt eye w/o graftAqueous shunt to extraocular equatorial plate reservoir, external approach; without graft

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65285	090	15.36	**RUC Time**

CPT Descriptor Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
53850	090	10.08	**RUC Time**	4,253

CPT Descriptor 1 Transurethral destruction of prostate tissue; by microwave thermotherapy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54437	090	11.50	**RUC Time**	51

CPT Descriptor 2 Repair of traumatic corporeal tear(s)

Other Reference CPT Code	Global	Work RVU	Time Source
67110	090	10.25	**RUC Time**

CPT Descriptor Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 25.8 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 19.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 66988	Top Key Reference CPT Code: 66179	2nd Key Reference CPT Code: **65285**
Median Pre-Service Time	38.00	25.00	60.00
Median Intra-Service Time	30.00	55.00	90.00
Median Immediate Post-service Time	7.00	10.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	108.0	163.00	154.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**202.00**	**272.00**	**353.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	63%	25%	12%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	37%	63%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	50%	50%
Physical effort required	0%	63%	37%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	33%	33%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	17%	83%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	17%	83%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 66988, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic* cyclophotocoagulation is a new CPT code combining cataract and IOL surgery with endoscopic ciliary ablation for glaucoma because the latter procedure is performed over 75% of

the time with cataract surgery. This procedure was previously reported with CPT 66984 and CPT 66711, and subject to the multiple procedure payment reduction.

A random survey of American Academy of Ophthalmology, American Society of Cataract and Refractive Surgeons, and American Glaucoma Society members had 31 respondents, 97% of whom found the vignette to be typical. The median WRVU was 13.95 and the 25th percentile was 11.08. The median IST was 30 minutes. The survey showed five 99213 postoperative visits. The top key reference service, chosen by 26% of respondents, was CPT 66179, *Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft* (RUC 2014), with a WRVU of 14.00, an IST of 55 minutes, and five level 3 and three level 2 postoperative visits. The second reference service, chosen by 19% of respondents, was CPT 65285, *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* (RUC 2011), with a WRVU of 15.36, an IST of 90 minutes, and six level 3 and one level 2 postoperative visits. The respondents ranked the surveyed code as similar or more intense and complex on the intensity and complexity measures compared to the key reference services.

The expert panel of the AAO, ASCRS, and AGS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The panel agreed with the median IST of 30 minutes and 5 postoperative visits. These patients typically have significantly greater than normal postoperative inflammation and unstable IOP due to the ciliary body ablation, necessitating frequent dilated examinations in the postoperative period to check for macular edema and peripheral retinal tears or detachments. However, the panel felt that rather than five 99213 visits as supported by the survey, the first postoperative visit should be a level 2, which is typical of the work associated with an undilated examination to check vision, pressure, incision integrity, and inflammation. As with the standalone ciliary photoablation procedure (CPT 67111), the subsequent postoperative visits at 1, 2, 4 and 6-8 weeks are all dilated level 3 visits to assess IOL position and presence of macular edema and peripheral retinal tears or detachments in addition to the portions of the exam that can be performed without dilation (checking vision, intraocular pressure, and status of the anterior segment of the eye).

We chose pre-service package 3 (straightforward patient, difficult procedure) as these are complex combined cases. We reduced the package pre-service evaluation time from 33 minutes to match the survey time of 25 minutes, which is necessary to review the prior history and explain the multiple surgical options that may be taken during the procedure. There is a risk of dislocating the lens implant during the ciliary ablation portion of the procedure, and the options to fixate the lens should that occur and its implications for planned outcome must be reviewed with the patient. We reduced the survey positioning time from 5 minutes to match the package time of 3 minutes, and reduced the package pre-service scrub, dress and wait time from 15 minutes to the survey time of 10 minutes. These patients typically require a greater wait time after the anesthetic injection than cataract surgery or ciliary ablation cases done alone because the combined cases take longer and involve direct cauterization of sensitive uveal tissue, so longer acting drugs which take longer to take effect (e.g. bupivacaine) are typically employed. The physician typically does a personal check of the settings and function of the photocoagulation unit and monitor and function of the light pipe prior to the incision. We used the survey post-service time median of 7 minutes, which is less than the 21 minutes of post-service time package 7B (local anesthesia, complex procedure), and one-half of a 99238 for discharge day management. Total time for the procedure is 202 minutes, with an IST of 30 minutes.

We were unable to find an adequate crosswalk for our initial recommendation of the survey's 25th percentile work value of 11.08. After pre-facilitation, we concluded that a crosswalk to CPT 67110, *Repair of retinal*

detachment; by injection of air or other gas (eg, pneumatic retinopexy) (RUC 2015), with 10.25 WRVU, 30 minutes IST and 196 minutes total time was appropriate. CPT 669871 has 1 less postoperative visit but more pre-time, and a greater portion of the procedure involves high-intensity intraocular manipulations compared to CPT 67110. **Therefore, we are recommending a work value for CPT 66988 of 10.25 WRVU, below the survey's 25th percentile, with times of 38/30/7 and a total time of 202 minutes.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 12000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimation Only

Specialty Ophthalmology Frequency 12000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimation Only

Specialty Ophthalmology Frequency 8000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Cataract removal/lens insertion

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 66984

SS Rec Summary

ISSUE: Cyclophotocoagulation

TAB: 11

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	npt/sam 38	npt/sam 39	Office 13	Office 12	Office 11
1st REF	67210	Destruction of localized lesion of retina (eg, macular edema		0.1991			6.36			106	10	5	2			15			5			3		
2nd REF	66185	Revision of aqueous shunt to extraocular equatorial plate		0.0601			10.58			259	19	1	5			65			10	0.5		4	3	
CURRENT	66711	Ciliary body destruction; cyclophotocoagulation,		0.0763			7.93			192	10	5	10			30			10	0.5		4	1	
SVY	66711	Ciliary body destruction; cyclophotocoagulation,	40	0.1533	6.00	7.85	9.01	10.69	75.00	193	25	5	6	8	15	20	20	60	10	0.5		4	1	
REC	**66711**	**Ciliary body destruction; cyclophotocoagulation, endoscopic**	**40**	**0.0230**			**6.36**			**191**	**25**	**3**	**6**			**20**			**10**	**0.5**		**4**	**1**	
XWALK	67210	Destruction of localized lesion of retina (eg, macular edema		0.1991			6.36			106	10	5	2			15			5			3		

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	npt/sam 38	npt/sam 39	Office 13	Office 12	Office 11
1st REF	67036	Vitrectomy, mechanical, pars plana approach;		0.1075			12.13			250	33	3	15			50			15	0.5		5		
2nd REF	65850	Trabeculotomy ab externo		0.1109			11.39			233	15	10	12.5			60			17.5	1.0			5	
CURRENT	66982	Extracapsular cataract removal with insertion of intraocular lens		0.2069			11.08			165	19	1	5			33			10	0.5		2	2	
SVY	66982	Extracapsular cataract removal with insertion of intraocular lens	92	0.2502	7.00	11.50	12.89	14.21	25.10	184	25	5	7	10	20	30	36	60	6	0.5		4		
REC	**66982**	**Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage**		**0.1801**			**10.25**			**175**	**25**	**3**	**7**			**30**			**6**	**0.5**		**3**	**1**	
XWALK	67110	Repair of retinal detachment; by injection of air or other gas (eg		0.1291			10.25			196	12	1	5			30			10			6		

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	npt/sam 38	npt/sam 39	Office 13	Office 12	Office 11
1st REF	66179	Aqueous shunt to extraocular equatorial plate reservoir, external		0.1156			14.00			272	19	1	5			55			10	0.5		5	3	
2nd REF	65285	Repair of laceration; cornea and/or sclera, perforating, with		0.0743			15.36			353	30	10	20			90			30	0.5		6	1	
CURRENT	None	66982 + 66711 with MPPR					15.05			0														
SVY	66987	Extracapsular cataract removal with insertion of intraocular lens	31	0.2173	8.88	13.50	14.88	16.22	34.36	241	30	5	10	20	30	36	48	90	10	0.5		5	1	
REC	**66987**	**Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage**		**0.1704**			**13.15**			**239**	**30**	**3**	**10**			**36**			**10**	**0.5**		**5**	**1**	

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	npt/sam 38	npt/sam 39	Office 13	Office 12	Office 11
1st REF	N/A																							
2nd REF	N/A																							

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	Z	AA	AH	AI	AJ
46	CURRENT	66983	Intracapsular cataract extraction with insertion of intraocular lens		0.0984			10.43			207.5	22		15			52			15			4.5		
47	SVY	N/A																							
48	**REC**	**66983**	**Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)**			**Contractor Price**																			
49																									
50																									
51	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**38**	**39**	**13**	**12**	**11**
52	1st REF	65850	Trabeculotomy ab externo		0.1109			11.39			233	15	10	12.5			60			17.5	1.0			5	
53	2nd REF	66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft		0.0485			9.58			254	19	1	5			60			10	0.5		4	3	
54	CURRENT	66984	Extracapsular cataract removal with insert		0.2096			8.52			147	16	1	5			21			7	0.5		2	2	
55	SVY	66984	Extracapsular cataract removal wit	93	0.3515	5.00	10.10	11.39	12.40	22.00	148	24	5	6	9	15	20	23	60	5	0.5		3		
56	**REC**	**66984**	**Extracapsular cataract removal with ins**		**0.1908**	**7.35**					**126**	**13**	**1**	**6**			**20**			**5**	**0.5**		**2**	**1**	
57	COMP	67210	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions;		0.1991	6.36					106	10	5	2	15					5			3		
58																									
59						**RVW**					**Total**	**PRE-TIME**			**INTRA-TIME**					**IMMD**	**npt/sam**		**Office**		
60	**Source**	**CPT**	**DESC**	**Resp**	**IWPUT**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**Time**	**EVAL**	**POSIT**	**SDW**	**MIN**	**25th**	**MED**	**75th**	**MAX**	**POST**	**38**	**39**	**13**	**12**	**11**
61	1st REF	66179	Aqueous shunt to extraocular equatorial plate reservoir, external		0.1156			14.00			272	19	1	5			55			10	0.5		5	3	
62	2nd REF	65285	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue		0.0743			15.36			353	30	10	20			90			30	0.5		6	1	
63	CURRENT	None	66984 + 66711 with MPPR					12.49			0														
64	SVY	66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure),	31	0.2517	7.30	11.08	13.95	14.93	28.00	211	25	5	10	12	25	30	40	100	7	0.5		5		
65	**REC**	**66988**	**Extracapsular cataract removal with ins**		**0.1462**	**10.25**					**202**	**25**	**3**	**10**			**30**			**7**	**0.5**		**4**	**1**	
66	**XWALK**	67110	Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)		0.1291	10.25					196	12	1	5			30			10			6		

CPT Code: 66711
Specialty Society: American Academy of Ophthalmology

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens

Global Period: 090 Meeting Date: January 2019

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: **N/A**

3. Is this code(s) typically billed with an E/M service? **No**

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A**

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: **N/A**

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: **N/A**

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. **N/A**

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Exam lane: Standard office visit formula used.
    Screening lane: Standard office visit formula used.

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**

13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

14. Please include an explanation of each line item:

    15 – Standard facility time input for completing pre-service diagnostic and referral forms
    16 – Standard facility time input for coordinating pre-surgery services
    17 – Standard facility time input for scheduling space and equipment in the facility
    18 – Standard facility time input for providing pre-service education/obtaining consent
    19 – Standard facility time input for completing pre-procedure phone calls and prescription
    74 – Standard facility time input for discharge day management
    88 – Typical number of 99212 post-op visits as demonstrated by RUC-approved survey
    89 – Typical number of 99213 post-op visits as demonstrated by RUC-approved survey
    102 – Ophthalmology visit pack with dilation for 99213 post-op visits
    103 – Ophthalmology visit pack without dilation for 99212 post-op visits

CPT Code: 66982
Specialty Society: American Academy of Ophthalmology

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation

Global Period: 090 Meeting Date: January 2019

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: **Existing code used as reference.**

3. Is this code(s) typically billed with an E/M service? **No**

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A**

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: **Post-operative visits were updated according to current practice patterns as demonstrated by the RUC-approved survey results. Standard times for visits were applied.**

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: **N/A**

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. **N/A**

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Exam lane: Standard office visit formula used.
    Screening lane: Standard office visit formula used.

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**

13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

14. Please include an explanation of each line item:

    15 – Standard facility time input for completing pre-service diagnostic and referral forms
    16 – Standard facility time input for coordinating pre-surgery services
    17 – Standard facility time input for scheduling space and equipment in the facility
    18 – Standard facility time input for providing pre-service education/obtaining consent
    19 – Standard facility time input for completing pre-procedure phone calls and prescription
    74 – Standard facility time input for discharge day management
    88 – Typical number of 99212 post-op visits as demonstrated by RUC-approved survey
    89 – Typical number of 99213 post-op visits as demonstrated by RUC-approved survey
    102 – Ophthalmology visit pack with dilation for 99213 post-op visits
    103 – Ophthalmology visit pack without dilation for 99212 post-op visits

CPT Code: 66987
Specialty Society: American Academy of Ophthalmology

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation

Global Period: 090 Meeting Date: January 2019

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: **This new code will represent when the current 66711 and 66982 are performed together. 66711 is the primary reference, but both 66711 and 66982 are listed in parallel on the excel sheet for reference.**

3. Is this code(s) typically billed with an E/M service? **No.**

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A**

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: **There is no current total cost for a combined code. However, the proposed total cost is marginally higher than either of the two individual current codes, exclusively because when the two codes are done in combination, there is typically one extra post-operative visit, as demonstrated by the RUC-approved survey.**

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: **N/A**

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. **N/A**

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Exam lane: Standard office visit formula used.
    Screening lane: Standard office visit formula used.

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**

13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

14. Please include an explanation of each line item:

    15 – Standard facility time input for completing pre-service diagnostic and referral forms
    16 – Standard facility time input for coordinating pre-surgery services
    17 – Standard facility time input for scheduling space and equipment in the facility
    18 – Standard facility time input for providing pre-service education/obtaining consent
    19 – Standard facility time input for completing pre-procedure phone calls and prescription
    74 – Standard facility time input for discharge day management
    88 – Typical number of 99212 post-op visits as demonstrated by RUC-approved survey
    89 – Typical number of 99213 post-op visits as demonstrated by RUC-approved survey
    102 – Ophthalmology visit pack with dilation for 99213 post-op visits
    103 – Ophthalmology visit pack without dilation for 99212 post-op visits

CPT Code: 66984
Specialty Society: American Academy of Ophthalmology

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation

Global Period: 090 Meeting Date: January 2019

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: **Existing code used as reference.**

3. Is this code(s) typically billed with an E/M service? **No**

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A**

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: **N/A**

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: **N/A**

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. **N/A**

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Exam lane: Standard office visit formula used.
    Screening lane: Standard office visit formula used.

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**

13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

14. Please include an explanation of each line item:

    15 – Standard facility time input for completing pre-service diagnostic and referral forms
    16 – Standard facility time input for coordinating pre-surgery services
    17 – Standard facility time input for scheduling space and equipment in the facility
    18 – Standard facility time input for providing pre-service education/obtaining consent
    19 – Standard facility time input for completing pre-procedure phone calls and prescription
    74 – Standard facility time input for discharge day management
    88 – Typical number of 99212 post-op visits as demonstrated by RUC-approved survey
    89 – Typical number of 99213 post-op visits as demonstrated by RUC-approved survey
    102 – Ophthalmology visit pack with dilation for 99213 post-op visits
    103 – Ophthalmology visit pack without dilation for 99212 post-op visits

CPT Code: 66988
Specialty Society: American Academy of Ophthalmology

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation

Global Period: 090 Meeting Date: January 2019

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. Additionally, we queried other physicians who have the appropriate expertise for this code. The consensus committee considered the survey data and PE details in order to determine clinical time and applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: **This new code will represent when the current 66711 and 66984 are performed together. 66711 is the primary reference, but both 66711 and 66984 are listed in parallel on the excel sheet for reference.**

3. Is this code(s) typically billed with an E/M service? **No.**

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A**

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: **There is no current total cost for a combined code. The total cost of this proposed code does not exceed that of 66711.**

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: **N/A**

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. **N/A**

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Exam lane: Standard office visit formula used.
    Screening lane: Standard office visit formula used.

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**

13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

14. Please include an explanation of each line item:

    15 – Standard facility time input for completing pre-service diagnostic and referral forms
    16 – Standard facility time input for coordinating pre-surgery services
    17 – Standard facility time input for scheduling space and equipment in the facility
    18 – Standard facility time input for providing pre-service education/obtaining consent
    19 – Standard facility time input for completing pre-procedure phone calls and prescription
    74 – Standard facility time input for discharge day management
    88 – Typical number of 99212 post-op visits as demonstrated by RUC-approved survey
    89 – Typical number of 99213 post-op visits as demonstrated by RUC-approved survey
    102 – Ophthalmology visit pack with dilation for 99213 post-op visits
    103 – Ophthalmology visit pack without dilation for 99212 post-op visits

	A	B	D	E	F	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**66982**		**66982**	
3		***RUC Collaboration Website***				Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or	
4	**Clinical Activity Code**	**Meeting Date: RUC January 2019 Tab: 11 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**					**90**		**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 95.07**	**$ -**	**$ 99.58**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38	**0.0**	**192.0**	**0.0**	**201.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38	**0.0**	**126.0**	**0.0**	**135.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 72.96**	**$ -**	**$ 76.38**
13		**PRE-SERVICE PERIOD**							
14		**Start: Following visit when decision for surgery or procedure made**							
15	CA001	Complete pre-service diagnostic and referral forms	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38		5		5
16	CA002	Coordinate pre-surgery services (including test results)	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38		20		20
17	CA003	Schedule space and equipment in facility	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38		8		8
18	CA004	Provide pre-service education/obtain consent	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38		20		20
19	CA005	Complete pre-procedure phone calls and prescription	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38		7		7
20	CA006	Confirm availability of prior images/studies	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
21	CA007	Review patient clinical extant information and questionnaire	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
29		**End: When patient enters office/facility for surgery/procedure**							
30		**SERVICE PERIOD**							
31		**Start: When patient enters office/facility for surgery/procedure:**							
32		**Pre-Service (of service period)**							
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
34	CA010	Obtain vital signs	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
35	CA011	Provide education/obtain consent	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
36	CA012	Review requisition, assess for special needs	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
37	CA013	Prepare room, equipment and supplies	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
38	CA014	Confirm order, protocol exam	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
39	CA015	Setup scope (nonfacility setting only)	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
41	CA017	Sedate/apply anesthesia	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
48		**Intra-service (of service period)**							
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician's or other qualified healthcare professional time (100%)	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician or other qualified healthcare professional time (67%)	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
51	CA020	Perform procedure/service---NOT directly related to physician work time	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
52	CA021		L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
59		**Post-Service (of service period)**							
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
61	CA023	Monitor patient following procedure/service, no multitasking	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
62	CA024	Clean room/equipment by clinical staff	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
63	CA025	Clean scope	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
64	CA026	Clean surgical instrument package	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L038A	COMT/COTR/CCHT/CCOT/RCST	0.38				

	A	B	D	E	F	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**	
2		****Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.*** ****Please do not modify formulas in gray shaded cells*** ****Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**66982**		**66982**	
3		***RUC Collaboration Website***				Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or	
4	**Clinical Activity Code**	**Meeting Date: RUC January 2019** **Tab: 11** **Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**					**90**		**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 95.07**	**$ -**	**$ 99.58**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**192.0**	**0.0**	**201.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**126.0**	**0.0**	**135.0**
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L038A	COMT/COT/RN/CST	0.38				
67	CA029	Check dressings, catheters, wounds	L038A	COMT/COT/RN/CST	0.38				
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L038A	COMT/COT/RN/CST	0.38				
69	CA031	Review examination with interpreting MD/DO	L038A	COMT/COT/RN/CST	0.38				
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L038A	COMT/COT/RN/CST	0.38				
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L038A	COMT/COT/RN/CST	0.38				
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L038A	COMT/COT/RN/CST	0.38				
73	CA035	Review home care instructions, coordinate visits/prescriptions	L038A	COMT/COT/RN/CST	0.38				
74	CA036	Discharge day management	L038A	COMT/COT/RN/CST	0.38	**n/a**	**6**	**n/a**	**6**
81		**End: Patient leaves office**							
82		**POST-SERVICE PERIOD**							
83		**Start: Patient leaves office/facility**							
84	CA037	Conduct patient communications	L038A	COMT/COT/RN/CST	0.38				
85	CA038	Coordinate post-procedure services	L038A	COMT/COT/RN/CST	0.38				
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16						
88		99212 27 minutes	27				2		1
89		99213 36 minutes	36				2		3
90		99214 53 minutes	53						
91		99215 63 minutes	63						
92	CA039	Post-operative visits (total time)	L038A	COMT/COT/RN/CST	0.38	**0.0**	**126.0**	**0.0**	**135.0**
99		**End: with last office visit before end of global period**							

	A	B	D	E	F	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**66982**		**66982**	
3		***RUC Collaboration Website***				Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Extracapsular cataract removal w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or	
4	**Clinical Activity Code**	**Meeting Date: RUC January 2019 Tab: 11 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**					**90**		**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 95.07**	**$ -**	**$ 99.58**
8		**TOTAL CLINICAL STAFF TIME**	L038A	~~UCOM/COTA~~	0.38	**0.0**	**192.0**	**0.0**	**201.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	~~UCOM/COTA~~	0.38	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	~~UCOM/COTA~~	0.38	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	~~UCOM/COTA~~	0.38	**0.0**	**126.0**	**0.0**	**135.0**
100	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**					
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 8.09**	**$ -**	**$ 8.99**
102	SA082	pack, ophthalmology visit (w-dilation)	2.4752	pack			2		3
103	SA050	pack, ophthalmology visit (no dilation)	1.5688	pack			2		1
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**				
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ 14.02**	**$ -**	**$ 14.20**
112	EL005	lane, exam (oph)	33811.17		0.10619106		132		108
113	EL006	lane, screening (oph)	32267.05		0.10134142				27
114									
115									
116									
117									
118		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*							

	A	B	M	N	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**66984**		**66984**		**66711**		**66711**		**66987**		**66988**	
3		***RUC Collaboration Website***	Extracapsular cataract extraction w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Extracapsular cataract extraction w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Ciliary body destruction; cyclophotocoagulation, endoscopic		Ciliary body destruction; cyclophotocoagulation, endoscopic		Combined ECP and Complex Cataract surgery		Combined ECP and Cataract surgery	
4	**Clinical Activity Code**	**Meeting Date: RUC January 2019 Tab: 11 Specialty: AAO**												
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		**90**		**90**		**90**		**90**		**90**		**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 95.07**	**$ -**	**$ 79.60**	**$ -**	**$ 120.59**	**$ -**	**$ 119.56**	**$ -**	**$ 139.54**	**$ -**	**$ 119.56**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**192.0**	**0.0**	**165.0**	**0.0**	**237.0**	**0.0**	**237.0**	**0.0**	**273.0**	**0.0**	**237.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**126.0**	**0.0**	**99.0**	**0.0**	**171.0**	**0.0**	**171.0**	**0.0**	**207.0**	**0.0**	**171.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ 72.96**	**$ -**	**$ 62.70**	**$ -**	**$ 90.06**	**$ -**	**$ 90.06**	**$ -**	**$ 103.74**	**$ -**	**$ 90.06**
13		**PRE-SERVICE PERIOD**												
14		**Start: Following visit when decision for surgery or procedure mad**												
15	CA001	Complete pre-service diagnostic and referral forms		5		5		5		5		5		5
16	CA002	Coordinate pre-surgery services (including test results)		20		20		20		20		20		20
17	CA003	Schedule space and equipment in facility		8		8		8		8		8		8
18	CA004	Provide pre-service education/obtain consent		20		20		20		20		20		20
19	CA005	Complete pre-procedure phone calls and prescription		7		7		7		7		7		7
20	CA006	Confirm availability of prior images/studies												
21	CA007	Review patient clinical extant information and questionnaire												
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)												
29		**End: When patient enters office/facility for surgery/procedure**												
30		**SERVICE PERIOD**												
31		**Start: When patient enters office/facility for surgery/procedure:**												
32		**Pre-Service (of service period)**												
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available												
34	CA010	Obtain vital signs												
35	CA011	Provide education/obtain consent												
36	CA012	Review requisition, assess for special needs												
37	CA013	Prepare room, equipment and supplies												
38	CA014	Confirm order, protocol exam												
39	CA015	Setup scope (nonfacility setting only)												
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient												
41	CA017	Sedate/apply anesthesia												
48		**Intra-service (of service period)**												
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)												
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)												
51	CA020	Perform procedure/service---NOT directly related to physician work time												
52	CA021													
59		**Post-Service (of service period)**												
60	CA022	Monitor patient following procedure/service, multitasking 1:4												
61	CA023	Monitor patient following procedure/service, no multitasking												
62	CA024	Clean room/equipment by clinical staff												
63	CA025	Clean scope												
64	CA026	Clean surgical instrument package												
65	CA027	Complete post-procedure diagnostic forms, fax and x-ray requisitions												

	A	B	M	N	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**66984**		**66984**		**66711**		**66711**		**66987**		**66988**	
3		***RUC Collaboration Website***	Extracapsular cataract extraction w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Extracapsular cataract extraction w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Ciliary body destruction; cyclophotocoagulation, endoscopic		Ciliary body destruction; cyclophotocoagulation, endoscopic		Combined ECP and Complex Cataract surgery		Combined ECP and Cataract surgery	
4	**Clinical Activity Code**	**Meeting Date: RUC January 2019 Tab: 11 Specialty: AAO**												
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		**90**		**90**		**90**		**90**		**90**		**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 95.07**	**$ -**	**$ 79.60**	**$ -**	**$ 120.59**	**$ -**	**$ 119.56**	**$ -**	**$ 139.54**	**$ -**	**$ 119.56**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**192.0**	**0.0**	**165.0**	**0.0**	**237.0**	**0.0**	**237.0**	**0.0**	**273.0**	**0.0**	**237.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**126.0**	**0.0**	**99.0**	**0.0**	**171.0**	**0.0**	**171.0**	**0.0**	**207.0**	**0.0**	**171.0**
66	CA028	Review/read post-procedure x-ray, lab and pathology reports												
67	CA029	Check dressings, catheters, wounds												
68	CA030	Technologist QC's images in PACS, checking for all images, reformats and dose prints												
69	CA031	Review examination with interpreting MD/DO												
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to												
71	CA033	Perform regulatory mandated quality assurance activity (service												
72	CA034	period) Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)												
73	CA035	Review home care instructions, coordinate visits/prescriptions												
74	CA036	Discharge day management	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**
81		**End: Patient leaves office**												
82		**POST-SERVICE PERIOD**												
83		**Start: Patient leaves office/facility**												
84	CA037	Conduct patient communications												
85	CA038	Coordinate post-procedure services												
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes												
88		99212 27 minutes		2		1		1		1		1		1
89		99213 36 minutes		2		2		4		4		5		4
90		99214 53 minutes												
91		99215 63 minutes												
92	CA039	Post-operative visits (total time)	**0.0**	**126.0**	**0.0**	**99.0**	**0.0**	**171.0**	**0.0**	**171.0**	**0.0**	**207.0**	**0.0**	**171.0**
99		**End: with last office visit before end of global period**												

	A	B	M	N	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**66984**		**66984**		**66711**		**66711**		**66987**		**66988**	
3		***RUC Collaboration Website***	Extracapsular cataract extraction w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Extracapsular cataract extraction w/ insertion of intraocular lens prosthesis (1 stage procedure), manual or		Ciliary body destruction; cyclophotocoagulation, endoscopic		Ciliary body destruction; cyclophotocoagulation, endoscopic		Combined ECP and Complex Cataract surgery		Combined ECP and Cataract surgery	
4	**Clinical Activity Code**	**Meeting Date: RUC January 2019 Tab: 11 Specialty: AAO**												
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		**90**		**90**		**90**		**90**		**90**		**90**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 95.07**	**$ -**	**$ 79.60**	**$ -**	**$ 120.59**	**$ -**	**$ 119.56**	**$ -**	**$ 139.54**	**$ -**	**$ 119.56**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**192.0**	**0.0**	**165.0**	**0.0**	**237.0**	**0.0**	**237.0**	**0.0**	**273.0**	**0.0**	**237.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**126.0**	**0.0**	**99.0**	**0.0**	**171.0**	**0.0**	**171.0**	**0.0**	**207.0**	**0.0**	**171.0**
100	**Supply**	**MEDICAL SUPPLIES**												
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ 8.09**	**$ -**	**$ 6.52**	**$ -**	**$ 12.38**	**$ -**	**$ 11.47**	**$ -**	**$ 13.94**	**$ -**	**$ 11.47**
102	SA082	pack, ophthalmology visit (w-dilation)		2		2		5		4		5		4
103	SA050	pack, ophthalmology visit (no dilation)		2		1				1		1		1
110	**Equipment Code**	**EQUIPMENT**												
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ 14.02**	**$ -**	**$ 10.38**	**$ -**	**$ 18.16**	**$ -**	**$ 18.03**	**$ -**	**$ 21.85**	**$ -**	**$ 18.03**
112	EL005	lane, exam (oph)		132		72		171		144		180		144
113	EL006	lane, screening (oph)				27				27		27		27
114														
115														
116														
117														
118		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*												

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Lacrimal Canaliculus Drug Eluting Implant Insertion – Tab 17

In October 2020, the CPT Editorial Panel replaced CPT Category III code 0356T with a new CPT Category I code to report the insertion of a drug eluting implant into the lacrimal canaliculus.

68841 ***Insertion of drug-eluting implant, including punctal dilation, when performed, into lacrimal canaliculus, each***
The RUC reviewed the survey results from 32 ophthalmologists for CPT code 68841 and agreed with the recommended direct work RVU crosswalk to CPT code 65205 *Removal of foreign body, external eye; conjunctival superficial* (work RVU = 0.49, 3 minutes of intra-service time, and 11 minutes total time) as it has identical intra-service time and an almost identical IWPUT. The RUC recommends 5 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 1 minute of pre-service scrub/dress/wait time, 3 minutes of intra-service time, 2 minutes of immediate post-service time, and 12 minutes total time for code 68841. The RUC recommended work RVU of 0.49 is lower than the survey 25th percentile work RVU of 0.74. The RUC agreed with the recommended work value of 0.49 using code 65205 as a direct work RVU crosswalk because both codes involve identical intra-service time and similar physician work and with the specialty society's explanation that the 3 minutes of intra-service time and nature of this procedure warrant a direct work RVU crosswalk lower than the survey 25th percentile value.

CPT code 68841 describes placement of a drug delivery device through an intact punctum into the lacrimal canaliculus. CPT code 68841 is typically performed in a facility in conjunction with intraocular surgery, typically cataract surgery (CPT codes 66982 and 66984) to deliver an extended-release dose of corticosteroid to treat postoperative inflammation. The device is a drug formulation that dissolves over the course of about a month. However, it can be placed in the office setting during the post-operative period if there is an unexpected degree of inflammation or the patient has trouble administering eyedrops. It can also be used off-label for treatment of non-surgical ocular inflammatory disease. The specialty societies noted that they expect utilization to increase in the office setting once implants containing medications for treatment of glaucoma or other non-surgical diseases are approved and introduced.

CPT code 68841 will be performed as a standalone code as implants containing other medications are introduced or as off-label treatment of non-surgical inflammation. The specialty societies noted that is why this is designated as a 000-day global service. The RUC agreed, noting that it would be subject to the multiple procedure reduction when applicable. The specialty societies confirmed that the only currently approved drug is used in conjunction with an intraocular surgical procedure and may be placed during surgery or in the office during the 1-day post-operative visit. As additional drugs are approved, these will likely be performed on the same day as an office visit. The specialty societies noted, and the RUC confirmed that the pre- and post-service times are much less than the established packages accounting for any overlap.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC compared CPT code 68841 to the top two key reference services, CPT code 65222 *Removal of foreign body, external eye; corneal, with slit lamp* (work RVU = 0.84, 7 minutes of intra-service time, 15 minutes total time) and CPT code 65800 *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* (work RVU = 1.53, 5 minutes of intra-service time, and 28 minutes of total time) and noted that the time and intensity of work of these procedures indicates an appropriate rank order for the recommended work RVU and total time for CPT code 68841. by CPT code 65205. For additional support, the RUC referenced CPT code 68200 *Subconjunctival injection* (work RVU = 0.49 and 11 minutes total time). **The RUC recommends a work RVU of 0.49 for CPT code 68841**.

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

Practice Expense
The Practice Expense Subcommittee recognized that if CPT code 68841 is done independently, the clinical staff time would be extensive; however, 68841 is typically done with cataract surgery, so the specialty chose to use minimal clinical staff time. Also, any duplication in the service period due to placement typically on postoperative day one from cataract surgery has been eliminated. **The RUC recommends the direct practice expense units as submitted by the specialty societies.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Eye and Ocular Adnexa** **Conjunctiva** **Lacrimal System** **Probing and/or Related Procedures**				
●68841	T1	Insertion of drug-eluting implant, including punctal dilation, when performed, into lacrimal canaliculus, each (For placement of drug-eluting ocular insert under the eyelid[s], see 0444T, 0445T) (Report drug-eluting implant separately with 99070 or appropriate supply code) (For insertion of drug-eluting implant [including punctal dilation and implant removal, when performed] into lacrimal canaliculus, use 68841)	000	0.49

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Repair

68760 *Closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery*

68761 *by plug, each*

(For insertion and removal of drug-eluting implant into lacrimal canaliculus for intra-ocular pressure, use 68841 ~~0356T~~)

(For placement of drug-eluting insert under the eyelid[s], see 0444T, 0445T)

Probing and/or Related Procedures

68815 *with insertion of tube or stent*

(See also 92018)

(For bilateral procedure, report 68815 with modifier 50)

(For insertion and removal of drug-eluting implant into lacrimal canaliculus for intra-ocular pressure, use 68841 ~~0356T~~)

(For placement of drug-eluting insert under the eyelid[s], see 0444T, 0445T)

Category III Codes

~~0356T~~	-	~~Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each~~ (0356T has been deleted) (For insertion of drug-eluting implant including punctal dilation, when performed, into the lacrimal canaliculus, use 68841)	~~YYY~~	N/A

0445T *Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral*

(For insertion and removal of drug-eluting implant into lacrimal canaliculus, use 68841 ~~0356T~~)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:68841 Tracking Number T1 Original Specialty Recommended RVU: **0.49**
Presented Recommended RVU: **0.49**
Global Period: 000 Current Work RVU: **N/A** RUC Recommended RVU: **0.49**

CPT Descriptor: Insertion of drug-eluting implant, including punctal dilation, when performed, into lacrimal canaliculus, each

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old female presents for cataract removal. a drug-eluting implant is placed in conjunction with the cataract removal.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient record. Discuss the planned procedure with the patient and family and obtain informed consent. Identify the position and patency of the lacrimal punctum. Reposition the patient and lower lid to expose the punctum. Administer topical anesthetic.

Description of Intra-Service Work: Insert a punctal dilator and advance into the canaliculus, dilating the punctum, then remove. Dry the punctum and surrounding tissue with a cotton-tipped applicator. Grasp the drug-eluting implant with forceps and insert through the punctum into the canaliculus. Bury the tip of the implant below the surface of the punctal opening.

Description of Post-Service Work: Complete an operative report. Discuss the procedure with the patient and family. Follow up exams as well as medications, activity and restrictions are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	David B. Glasser, MD (AAO); Ankoor R. Shah, MD (AAO); Parag Parekh, MD (ASCRS)					
Specialty Society(ies):	American Academy of Ophthalmology (AAO) & American Society of Cataract and Refractive Surgery (ASCRS)					
CPT Code:	68841					
Sample Size:	2622	**Resp N:**	32			
Description of Sample:	Random sample of practicing ophthalmologists of the AAO and ASCRS					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	9.00	**16.00**	30.00	350.00
Survey RVW:		0.15	0.74	**0.83**	1.09	2.12
Pre-Service Evaluation Time:				**5.00**		
Pre-Service Positioning Time:				**2.00**		
Pre-Service Scrub, Dress, Wait Time:				**2.00**		
Intra-Service Time:		1.00	2.00	**3.00**	6.00	15.00
Immediate Post Service-Time:	**2.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	68841	**Recommended Physician Work RVU: 0.49**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**13.00**	**-8.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**1.00**	**6.00**	**-5.00**
Intra-Service Time:		**3.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**2.00**	**18.00**	**-16.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65222	000	0.84	**Other**

CPT Descriptor Removal of foreign body, external eye; corneal, with slit lamp

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
65800	000	1.53	**RUC Time**

CPT Descriptor Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29540	000	0.39	**RUC Time**	213,060

CPT Descriptor 1 Strapping; ankle and/or foot

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
51702	000	0.50	**RUC Time**	234,004

CPT Descriptor 2 Insertion of temporary indwelling bladder catheter; simple (eg, Foley)

Other Reference CPT Code	Global	Work RVU	Time Source
65205	000	0.49	**RUC Time**

CPT Descriptor Removal of foreign body, external eye; conjunctival superficial

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 31.2 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 18.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 68841	Top Key Reference CPT Code: 65222	2nd Key Reference CPT Code: **65800**
Median Pre-Service Time	7.00	5.00	18.00
Median Intra-Service Time	3.00	7.00	5.00
Median Immediate Post-service Time	2.00	3.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**12.00**	**15.00**	**28.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	20%	40%	30%	10%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	40%	30%	30%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	70%	30%
Physical effort required	10%	70%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and	40%	50%	10%

judgment of physician • Estimated risk of malpractice suit with poor outcome	

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	33%	0%	50%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	33%	33%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	67%	33%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	50%	33%	17%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT 68841, *Insertion of drug-eluting implant, including punctal dilation, when performed, into lacrimal canaliculus, each* is a new 000-day global CPT code for placement of drug-eluting canalicular implants that can replace or supplement topical eyedrop administration.

This procedure was previously reported with CPT 0356T. There is no claims data available because at this time the only FDA-approved drug for this procedure, a dexamethasone-eluting implant, was introduced to the market in the third quarter of 2020. The procedure is typically performed in a facility in conjunction with cataract surgery (CPT 66982, 66984) or another intraocular procedure at this time. However, it can be placed in the office during the postoperative period if there is an unexpected degree of inflammation or the patient experiences difficulty administering eyedrops. It can also be used off-label for treatment of non-surgical ocular inflammatory

disease. We expect additional office utilization once implants containing medications for treatment of glaucoma or other non-surgical diseases are approved and introduced.

There are two other codes in the "Lacrimal System: Repair" section of CPT that might be considered in the same family as CPT 68841: CPT 68760 and 68761. The other codes in this section of CPT (68700-68750, 68770) are not remotely related in terms of the details of the surgical procedures and diseases they treat despite their listing in the same section of CPT. They are therefore not in the same family of procedures.

CPT 68760 and 68761 differ significantly from CPT 68841 in a number of essential characteristics. First, CPT 68841 is typically performed in a facility, while CPT 68760 and 68761 are performed in the office 86.8% and 96.7% of the time, respectively. Second, 68841 describes placement of a drug delivery device through an intact punctum into the lacrimal canaliculus, while the two existing procedures describe closure of the punctum. Third, they are used in different circumstances for different clinical indications.

CPT 68841 is used in conjunction with intraocular surgery, typically cataract removal, to deliver an extended release dose of corticosteroid to treat postoperative inflammation. The device is a drug formulation that dissolves over the course of about a month. CPT 68760 and 68761 are not typically used in conjunction with any other surgical procedure and are not drug delivery systems. They are typically reported with an office visit and are done to close the punctum to treat ocular surface disease due to dry eye.

For the above reasons, both CPT 68760 and 68761 are in a separate family from CPT 68841 and are not being reviewed at this time.

A survey of 68841 sent to a random sample of American Academy of Ophthalmology and American Society of Cataract and Refractive Surgery members had 32 respondents, 88% of whom found the vignette to be typical. The median WRVU was 0.83 and the 25th percentile was 0.74. The median IST was 3 minutes. The expert panel of the AAO and ASCRS, which is familiar with the procedure and the RUC process, reviewed the survey findings. The procedure is very new, the drug having been introduced in the third quarter of 2020. Although there was an adequate service performance rate, some respondents may still have been on the initial learning curve at the time of the survey.

The top key reference service, chosen by 31% of respondents, was CPT 65222, *Removal of foreign body, external eye; corneal, with slit lamp* (RUC 2011), with a WRVU of 0.84, an IST of 7 minutes, and a total time of 15 minutes. The second reference service, chosen by 19% of respondents, was CPT 65800, *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* (RUC 2012), with a WRVU of 1.53, an IST of 5 minutes, and a total time of 28 minutes. While 40% of respondents ranked the surveyed code identical on the overall intensity and complexity measure, 40% ranked it somewhat or much more complex than the top reference service. The majority ranked the codes identical on the submeasures. The majority ranked the surveyed code higher than the second reference service on overall intensity and complexity and physical effort, ranking them identical on the technical skill submeasure. These rankings were paradoxical in that respondents found the surveyed code more complex than a high-IWPUT intraocular procedure, yet similar in complexity to a lower-IWPUT extraocular procedure. Only 6 respondents chose the intraocular procedure as a reference, and they may have been among those early in their learning curve with the new procedure.

The panel agreed with the survey median IST of 3 minutes. We considered valuing 68841 as an add-on ZZZ procedure with no pre- or post-service time. However, the procedure will be done as a standalone as implants containing other medications are introduced or as off-label treatment of non-surgical inflammation. Therefore, we are valuing the code as a 000-day global. There will be an opportunity to revisit utilization patterns when it is reviewed under the New Technology screen.

Pre-service package 1 is appropriate for a procedure typically performed in a facility. Because CPT 68841 is currently performed in conjunction with intraocular surgery, times would be expected to be shorter than the package times. Survey respondents appeared to recognize this, perhaps because the vignette states that the procedure is done in conjunction with cataract removal.

We used the survey pre-service evaluation time of 5 minutes, substantially lower than the package time of 13 minutes. Five minutes is necessary to discuss the aspects of the procedure that are separate from the associated intraocular surgery, obtain a separate informed consent, and identify the location and patency of the lacrimal punctum in the preoperative area. All of this is distinct from and in addition to the work associated with the concurrent intraocular procedure.

We reduced the survey positioning time of 2 minutes to match the package time of 1 minute. Positioning time in addition to that of the associated procedure is required because the drug-eluting implant is placed after the intraocular procedure's intra-service work is completed. After the drapes and lid speculum are removed, which is part of the intraocular procedure, the head must be repositioned to center the lacrimal punctum in the microscope field of view. The lid must then be everted and angled to make the lacrimal punctum accessible. This occurs after conclusion of the intraocular procedure and is separate from the positioning performed at the beginning of the intraocular procedure. We allocated 1 minute for positioning, consistent with the package time and less than the survey value of 2 minutes.

We reduced the 2-minute survey scrub/dress/wait time to 1 minute. This time is required to allow administration and onset of topical anesthesia prior to implant insertion. It is consistent with the detailed breakdown of pre-service package 1. As with the positioning, this too occurs after the conclusion of, and is in addition to the scrub/dress/wait time for the associated intraocular procedure.

The survey immediate postoperative time of 2 minutes is needed to complete the portion of the operative report unique to the implant insertion and to discuss symptoms of implant extrusion.

The pre-, intra-, and post- times for the procedure are 7/3/2, with a total time of 12 minutes.

We recommend a work value for CPT 68841 of 0.49 WRVU, below the survey 25th percentile, with a crosswalk to CPT 65205, *Removal of foreign body, external eye; conjunctival superficial* (RUC 2017). The crosswalk code has an identical IST of 3 minutes and a total time of 11 minutes, within 1 minute of the surveyed code. The IWPUT at this work value is almost identical to that of the crosswalk code, though we recognize that IWPUTs are unreliable for such brief procedures. The recommended value is further supported by CPT 68200, *Subconjunctival injection of medication or other substance into Tenon's capsule* (RUC 2011) with 0.49 WRVU, an IST of 5 minutes, and a total time of 11 minutes.

The panel also considered a crosswalk to CPT 67820, *Correction of trichiasis; epilation, by forceps only* (RUC 2016), with 0.32 WRVU, an IST of 5 minutes, and a total time of 11 minutes. The panel felt that the work, intensity, and precision of inserting an implant through the punctum in an eye with a fresh surgical incision is better represented by the crosswalk to a foreign body removal or a subconjunctival injection.

We recommend a work value of 0.49 WRVU for CPT 68841, with times of 7/3/2 and a total time of 12 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☒ Other reason (please explain) The only currently approved drug is used in conjunction with an intraocular surgical procedure, and may be placed during surgery or in the office during the 1-day postoperative visit. As additional drugs are approved, these will likely be performed on the same day as an office visit.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	CPT Code	Pre-	Intra-	Post-	Total Time	Work RVU	Global Period
4.	66982	35	30	6	175	10.25	090
5.	66984	20	20	5	126	7.35	090

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0356T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 100000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate.

Specialty Ophthalmology Frequency 100000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 45,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate.

Specialty Ophthalmology Frequency 45000 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Eye procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 66984

SS Rec Summary

ISSUE: Lacrimal Canaliculus Drug Eluting Implant Insertion (68841)

TAB: 17

source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	65222	000	Removal of fo	10	0.094	0.056			0.84			15	5					7			3																
2nd REF	65800	000	Paracentesis	6	0.217	0.055			1.53			28	12	1	5			5			5																
CURRENT	NA	000	NA		#DIV/0!	#DIV/0!						0																									
SVY	68841	000	Insertion of dr	32	0.204	0.059	0.15	0.74	0.83	1.09	2.12	14	5	2	2	1	2	3	6	15	2													0	9	16	30	350
XWALK	65205	000	Removal of foreign b		0.108	0.045			0.49			11	3		1			3			4																
REC	68841	000	Insertion of drug-elu		0.101	0.041			0.49			12	5	1	1			3			2																

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_68841___**
SPECIALTY SOCIETY(IES):_AAO, ASCRS__
PRESENTER(S):__ Ankoor Shah, David Glasser, and Parag Parekh
—

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
68841	Insertion of drug-eluting implant, including punctal dilation, when performed, into lacrimal canaliculus, each	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
68841	A 67-year-old female presents for cataract removal. a drug-eluting implant is placed in conjunction with the cataract removal.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. The consensus committee considered the survey data and PE details to determine clinical time. Additionally, applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   First Reference Code 65222 Removal of corneal foreign body – this was chosen based on the survey results indicating this as the top reference code
   Second Reference Code 68761 Closure of lacrimal punctum by plug, each – this was chosen based on the similarity of the procedure. The major difference between this code and 68841, is that a device to block the punctum is inserted vs a drug eluting agent that is placed through the punctum into the canaliculus.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   CPT 0356T has no claims data thus the answers below are anticipated:
   Ophthalmology.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Presume 5% done in the non-facility setting and 95% will be done in the facility setting.
Dominant provider should be the same in both settings – ophthalmology.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

No

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

The clinical staff time if done independently would be extensive; however, since this is typically done with cataract surgery we have chosen to use minimal clinical staff time. Furthermore, reductions beyond those levels have been made where appropriate.
CA001 – This time is used to complete pre-service referral forms. Because this additional drug approval for the actual implant that is inserted this is additional time beyond what would be included for cataract surgery and not duplicative. The standard times have been used.
CA004 – This is to provide pre-service education and consent. Despite being done with cataract surgery, the procedure and associated risks and benefits are different and still require additional discussion. The standard times have been used.
CA002, CA003, and CA005 Have been reduced from 3 minutes to 0 minutes.

   b. Service period (includes pre, intra and post):

Duplication due to placement typically on postoperative day one from cataract surgery has been eliminated.
CA013 – Staff would prepare the room and supplies for the procedure. This requires instrumentation and setup beyond a cataract postoperative visit, thus the standard time of 2 minutes in completed.

   c. Post-service period:

CA024 – The room and equipment are cleaned. The full allotment of standard time is included because both a punctal dilator and 45-degree forceps that are used need to be scrubs, cleaned, repacked, and sterilized. These are instruments not used on a postoperative cataract surgery visit.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

CA035 – Review of instructions specific to this device are performed. These are risks separate from cataract surgery and include discussion of care of the eyelid, need to evaluate for extrusion of device, etc. This has been reduced from the standard time of 2 minutes to 1 minute.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A. Typically the physician performs the procedure and staff help with setup, cleanup, post procedure counselling etc.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

SB024 – Sterile Gloves, required for the procedure performed by the physician. Sterile gloves required due to recent cataract surgery and potential for infecting the eye through recent incisions
SG081 – Cotton tip applicators – these are required above and beyond a normal postoperative visit to facilitate eversion of the eyelids for placement of the implant.
SJ043 – Povidone swabsticks – needed for sterility for the above-mentioned reasons.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

SH058 – Proparacaine – required for anesthesia.

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):
    N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

    N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:
    EL006 – Screening lane is used for the duration of setup, procedure, cleaning, and counselling post procedure. Standard formulas applied.

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:
    N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:
    N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made

during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPTCODE(S):_68841___**
SPECIALTY SOCIETY(IES):__AAO, ASCRS_____
PRESENTER(S):_Ankoor Shah, David Glasser, and Parag Parekh__

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
68841	Insertion of drug-eluting implant, including punctal dilation, when performed, into lacrimal canaliculus, each	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
68841	A 67-year-old female presents for cataract removal. a drug-eluting implant is placed in conjunction with the cataract removal.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The Academy convenes a consensus subcommittee utilizing the appropriate subspecialty representatives who sit on our Health Policy Committee that oversees our activities at RUC and CPT. The consensus committee considered the survey data and PE details to determine clinical time. Additionally, applicable standard packages were also applied. The physicians on the consensus panel familiar with the service provided input on whether or not any changes were needed for the existing supplies and equipment.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   First Reference Code 65222 Removal of corneal foreign body – this was chosen based on the survey results indicating this as the top reference code
   Second Reference Code 68761 Closure of lacrimal punctum by plug, each – this was chosen based on the similarity of the procedure. The major difference between this code and 68841, is that a device to block the punctum is inserted vs a drug eluting agent that is placed through the punctum into the canaliculus

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

The clinical staff time if done independently would be extensive; however, since this is typically done with cataract surgery we have chosen to use minimal clinical staff time. Furthermore, reductions beyond those levels have been made where appropriate. CA001 – This time is used to complete pre-service referral forms. Because this additional drug approval for the actual implant that is inserted this is additional time beyond what would be included for cataract surgery and not duplicative. The standard times have been used. CA003 – This service is typically at the facility and requires additional time to ensure drug to be implanted are ordered for placement in the facility setting. This is reduced further from the standard 3 minutes to 1 minute. CA004 – This is to provide pre-service education and consent. Despite being done with cataract surgery, the procedure and associated risks and benefits are different and still require additional discussion. The standard times have been used. CA002 and CA005 Have been reduced from 3 minutes to 0 minutes.

   b. Service period (includes pre, intra and post):

None.

   c. Post-service period:

None.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

None in the facility setting

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

None in the facility setting.

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**2nd REFERENCE CODE**		**REC**
2						**65222**		**68761**		
3		***RUC Collaboration Website***								
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 17 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Removal of Corneal Foreign Body w/ Slit Lamp		Closure of the lacrimal punctum; by plug, each		insertio implant, dilation, wh lacrimal
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**000**	**000**	**010**	**010**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 17.00**	**$ 3.80**	**$ 54.47**	**$ 29.66**	**$ 7.51**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/ RN/CST	0.38	**31.0**	**10.0**	**56.0**	**63.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/ RN/CST	0.38	**5.0**	**10.0**	**18.0**	**30.0**	**6.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/ RN/CST	0.38	**23.0**	**0.0**	**11.0**	**6.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/ RN/CST	0.38	**3.0**	**0.0**	**27.0**	**27.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 11.78**	**$ 3.80**	**$ 21.28**	**$ 23.94**	**$ 4.56**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**	L038A							
15	CA001	Complete pre-service diagnostic and referral forms	L038A	COMT/COT/ RN/CST	0.38	5	5	5	5	3
16	CA002	Coordinate pre-surgery services (including test results)	L038A	COMT/COT/ RN/CST	0.38			3	10	0
17	CA003	Schedule space and equipment in facility	L038A	COMT/COT/ RN/CST	0.38		5	0	5	0
18	CA004	Provide pre-service education/obtain consent	L038A	COMT/COT/ RN/CST	0.38			7	7	3
19	CA005	Complete pre-procedure phone calls and prescription	L038A	COMT/COT/ RN/CST	0.38			3	3	0
20	CA006	Confirm availability of prior images/studies	L038A	COMT/COT/ RN/CST	0.38					
21	CA007	Review patient clinical extant information and questionnaire	L038A	COMT/COT/ RN/CST	0.38					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L038A	COMT/COT/ RN/CST	0.38					
23			L038A	COMT/COT/ RN/CST	0.38					
26		*Other activity: please include short clinical description here and type new in col.num 4*	L038A	COMT/COT/ RN/CST	0.38					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L038A	COMT/COT/ RN/CST	0.38	3		3		0
34	CA010	Obtain vital signs	L038A	COMT/COT/ RN/CST	0.38	2		3		0
35	CA011	Provide education/obtain consent	L038A	COMT/COT/ RN/CST	0.38	2		2		0
36	CA012	Review requisition, assess for special needs	L038A	COMT/COT/ RN/CST	0.38					
37	CA013	Prepare room, equipment and supplies	L038A	COMT/COT/ RN/CST	0.38	2				2
38	CA014	Confirm order, protocol exam	L038A	COMT/COT/ RN/CST	0.38					
39	CA015	Setup scope (nonfacility setting only)	L038A	COMT/COT/ RN/CST	0.38					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COT/ RN/CST	0.38					
41	CA017	Sedate/apply anesthesia	L038A	COMT/COT/ RN/CST	0.38					
42			L038A	COMT/COT/ RN/CST	0.38					
45		*Other activity: please include short clinical description here and type new in col.num 4*	L038A	COMT/COT/ RN/CST	0.38					
48		**Intra-service (of service period)**								
49	CA018	Assist physician of other qualified healthcare professional---directly related	L038A	COMT/COT/ RN/CST	0.38					
50	CA019	Assist physician of other qualified healthcare professional---directly related	L038A	COMT/COT/ RN/CST	0.38	11				
51	CA020	Assist physician of other qualified healthcare professional---directly related to physician work time (other%)	L038A	COMT/COT/ RN/CST	0.38					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L038A	COMT/COT/ RN/CST	0.38					
55			L038A	COMT/COT/ RN/CST	0.38					
56		*Other activity: please include short clinical description here and type new in col.num 4*	L038A	COMT/COT/ RN/CST	0.38					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L038A	COMT/COT/ RN/CST	0.38					
61	CA023	Monitor patient following procedure/service, no multitasking	L038A	COMT/COT/ RN/CST	0.38					
62	CA024	Clean room/equipment by clinical staff	L038A	COMT/COT/ RN/CST	0.38	3		3		3
63	CA025	Clean scope	L038A	COMT/COT/ RN/CST	0.38					
64	CA026	Clean surgical instrument package	L038A	COMT/COT/ RN/CST	0.38					
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L038A	COMT/COT/ RN/CST	0.38					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L038A	COMT/COT/ RN/CST	0.38					
67	CA029	Check dressings, catheters, wounds	L038A	COMT/COT/ RN/CST	0.38					
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, marked	L038A	COMT/COT/ RN/CST	0.38					
69	CA031	Review examination with interpreting MD/DO	L038A	COMT/COT/ RN/CST	0.38					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	L038A	COMT/COT/ RN/CST	0.38					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L038A	COMT/COT/ RN/CST	0.38					
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L038A	COMT/COT/ RN/CST	0.38					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L038A	COMT/COT/ RN/CST	0.38					1
74	CA036	Discharge day management	L038A	COMT/COT/ RN/CST	0.38	**n/a**		**n/a**	**6**	**n/a**
75			L038A	COMT/COT/ RN/CST	0.38					
78		*Other activity: please include short clinical description here and type new in col.num 4*	L038A	COMT/COT/ RN/CST	0.38					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L038A	COMT/COT/ RN/CST	0.38					
85	CA038	Coordinate post-procedure services	L038A	COMT/COT/ RN/CST	0.38	3				
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27					1	1	
89		99213 36 minutes	36							
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L038A	COMT/COT/ RN/CST	0.38	**0.0**	**0.0**	**27.0**	**27.0**	**0.0**
93			L038A	COMT/COT/ RN/CST	0.38					
96		*Other activity: please include short clinical description here and type new in col.num 4*	L038A	COMT/COT/ RN/CST	0.38					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**2nd REFERENCE CODE**		**REC**
2						**65222**		**68761**		
3		***RUC Collaboration Website***				Removal of Corneal Foreign Body w/ Slit Lamp		Closure of the lacrimal punctum; by plug, each		insertio implant, dilation, wh lacrimal
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 17 Specialty: AAO**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**000**	**000**	**010**	**010**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 17.00**	**$ 3.80**	**$ 54.47**	**$ 29.66**	**$ 7.51**
8		**TOTAL CLINICAL STAFF TIME**	L038A	COMT/COT/ RN/CST	0.38	**31.0**	**10.0**	**56.0**	**63.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/ RN/CST	0.38	**5.0**	**10.0**	**18.0**	**30.0**	**6.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/ RN/CST	0.38	**23.0**	**0.0**	**11.0**	**6.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/ RN/CST	0.38	**3.0**	**0.0**	**27.0**	**27.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 2.34**	**$ -**	**$ 28.63**	**$ 2.34**	**$ 1.82**
102	SA050	pack, ophthalmology visit (no dilation)	2.3363	pack		1	0	2	1	0
103	SB024	gloves, sterile	0.8925	pair				1	0	1
104	SG070	punctum plug	44.9875	pair				0.5	0	0
105	SG081	applicator, cotton-tipped, sterile, 6in	0.0562	item				2	0	2
106	SJ043	povidone swabsticks (3 pack uou)	0.4622	item				1	0	1
107	SH058	proparacaine 0.5% ophth (Ophthaine, Alcaine)	1.7737	ml						0.2
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 2.88**	**$ -**	**$ 4.56**	**$ 3.38**	**$ 1.13**
112	EL006	lane, screening (oph)	39874.4787		0.125234158	23	0	36	27	9
113	EQ176	loupes, standard, up to 3.5x	1412.8762		0.004560244			11	0	0
114										
115										
116										
117										
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	L
1	**RUC Practice Expense Spreadsheet**		**OMMENDED**
2			**68841**
3		***RUC Collaboration Website***	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 17** **Specialty: AAO**	h of drug-eluting ncluding punctal en performed, into canaliculus, each
5		**LOCATION**	**Facility**
6		**GLOBAL PERIOD**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.66**
8		**TOTAL CLINICAL STAFF TIME**	**7.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**7.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 2.66**
13		**PRE-SERVICE PERIOD**	
14		**Start: Following visit when decision for surgery/procedure made**	
15	CA001	Complete pre-service diagnostic and referral forms	3
16	CA002	Coordinate pre-surgery services (including test results)	0
17	CA003	Schedule space and equipment in facility	1
18	CA004	Provide pre-service education/obtain consent	3
19	CA005	Complete pre-procedure phone calls and prescription	0
20	CA006	Confirm availability of prior images/studies	
21	CA007	Review patient clinical extant information and questionnaire	
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	
23			
26		*Other activity: please include short clinical description here and type new in column A*	
29		**End: When patient enters office/facility for surgery/procedure**	
30		**SERVICE PERIOD**	
31		**Start: When patient enters office/facility for surgery/procedure:**	
32		**Pre-Service (of service period)**	
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are visible	
34	CA010	Obtain vital signs	
35	CA011	Provide education/obtain consent	
36	CA012	Review requisition, assess for special needs	
37	CA013	Prepare room, equipment and supplies	
38	CA014	Confirm order, protocol exam	
39	CA015	Setup scope (nonfacility setting only)	
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	
41	CA017	Sedate/apply anesthesia	
42			
45		*Other activity: please include short clinical description here and type new in column A*	
48		**Intra-service (of service period)**	
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)	
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)	
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)	
52	CA021	Perform procedure/service---NOT directly related to physician work time	
55			
56		*Other activity: please include short clinical description here and type new in column A*	
59		**Post-Service (of service period)**	
60	CA022	Monitor patient following procedure/service, multitasking 1:4	
61	CA023	Monitor patient following procedure/service, no multitasking	
62	CA024	Clean room/equipment by clinical staff	
63	CA025	Clean scope	
64	CA026	Clean surgical instrument package	
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	
67	CA029	Check dressings, catheters, wounds	
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, markers	
69	CA031	Review examination with interpreting MD/DO	
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into workqueue	
71	CA033	Perform regulatory mandated quality assurance activity (service period)	
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	
73	CA035	Review home care instructions, coordinate visits/prescriptions	
74	CA036	Discharge day management	
75			
78		*Other activity: please include short clinical description here and type new in column A*	
81		**End: Patient leaves office/facility**	
82		**POST-SERVICE PERIOD**	
83		**Start: Patient leaves office/facility**	
84	CA037	Conduct patient communications	
85	CA038	Coordinate post-procedure services	
86		***Office visits: List Number and Level of Office Visits***	**# visits**
87		99211 16 minutes	
88		99212 27 minutes	
89		99213 36 minutes	
90		99214 53 minutes	
91		99215 63 minutes	
92	CA039	Post-operative visits (total time)	**0.0**
93			
96		*Other activity: please include short clinical description here and type new in column A*	
99		**End: with last office visit before end of global period**	

	A	B	L
1	**RUC Practice Expense Spreadsheet**		**OMMENDED**
2			**68841**
3		***RUC Collaboration Website***	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 17** **Specialty: AAO**	n of drug-eluting ncluding punctal en performed, into canaliculus, each
5		**LOCATION**	**Facility**
6		**GLOBAL PERIOD**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.66**
8		**TOTAL CLINICAL STAFF TIME**	**7.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**7.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**
102	SA050	pack, ophthalmology visit (no dilation)	0
103	SB024	gloves, sterile	0
104	SG070	punctum plug	0
105	SG081	applicator, cotton-tipped, sterile, 6in	0
106	SJ043	povidone swabsticks (3 pack uou)	0
107	SH058	proparacaine 0.5% ophth (Ophthaine, Alcaine)	0
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*	
110	**Equipment Code**	**EQUIPMENT**	
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**
112	EL006	lane, screening (oph)	
113	EQ176	loupes, standard, up to 3.5x	
114			
115			
116			
117			
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Transcutaneous Passive Implant-Temporal Bone – Tab 18

In October 2020, the CPT Editorial replaced two codes for mastoidectomy with new codes for magnetic transcutaneous attachment to external speech processor. Additional revisions and codes were added to differentiate implantation, removal, and replacement of the implants.

69714 ***Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor***
The RUC reviewed the survey results from 73 physicians and determined that a work RVU of 8.69 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 40 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and two office visit(s) (2x 99213).

The RUC recommends a direct work RVU crosswalk to CPT code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (work RVU= 8.69, intra-service time of 40 minutes and 197.5 minutes of total time) and noted that both codes have identical intra-service time, similar total time, and should be valued identically. The RUC agreed that due to the lack of 090-day global codes with 40 minutes of intra-service time, CPT code 52400 is an appropriate crosswalk for the work value, resulting in a work intensity that closely aligns with the revision/replacement of implant code 69717 (0.110 and 0.100 IWPUT respectively). The RUC agreed that code 52400 and the survey code have similar intra-service and total times and should be valued identically, below the survey's 25th percentile. **The RUC recommends an interim work RVU of 8.69 for CPT code 69714.**

69716 ***Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***
The RUC reviewed the survey results from 67 physicians and determined that a work RVU of 9.77 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 32 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra-service time of 60, immediate post service time of 15 minutes and total time of 207 minutes) and noted that both codes have identical intra-service time, identical post-service time and similar total time, and should be valued identically. The RUC agreed that an IWPUT of 0.100 is appropriate and that the recommended work value of 9.77 places the survey code well within the relativity of the family.

Additionally, the RUC agreed that the work value of 9.77 for code 69716 is appropriately bracketed by codes 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03 and total time of 201 minutes) and 57240 *Anterior*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed (work RVU = 10.08 and total time of 211 minutes), further supporting a recommended work RVU of 9.77 for code 69716. **The RUC recommends an interim work RVU of 9.77 for CPT code 69716.**

69717 ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor***
The RUC reviewed the survey results from 64 physicians and determined that a work RVU of 8.80 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and two office visit(s) (2x 99213).

The RUC recommends a direct work RVU crosswalk to CPT code 27829 *Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed* (work RVU= 8.80 and intra-service time of 45 minutes) to appropriately account for the physician work involved in this service. The RUC agreed that code 27829 is an appropriate crosswalk, the recommended work value of 8.80 for the survey code results in an IWPUT of 0.100. Additionally, the RUC agreed that the survey code should be valued identically to code 27829 because both services have identical intra-service time. **The RUC recommends an interim work RVU of 8.80 for CPT code 69717.**

69719 ***Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***
The RUC reviewed the survey results from 59 physicians and determined that the work RVU of 9.77 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 60 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), and two office visit(s) (2x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU = 9.77, intra-service time of 60 minutes and total time of 207 minutes). The RUC agreed that the crosswalk to MPC code 50590 and recommended work value of 9.77 appropriately accounts for the physician work involved in this service because both codes have identical intra-service time, identical post-service time and similar total time. The RUC agreed that an IWPUT of 0.099 is appropriate and that the recommended work value of 9.77 places the survey code well within the relativity of the family.

Additionally, the RUC agreed that the work value of 9.77 for code 69719 is appropriately bracketed by codes 43180 *Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed* (work RVU = 9.03 and total time of 201 minutes) and 57240 *Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed* (work RVU = 10.08 and total time of 211 minutes), further warranting a recommended work RVU of 9.77 for code 69719. **The RUC recommends an interim work RVU of 9.77 for CPT code 69719.**

69726 ***Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor***
CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC reviewed the survey results from 66 physicians and determined that the work RVU of 5.93 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 32 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 30 minutes of intra-service time, and 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and one office visit(s) (1x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to code 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU = 5.93, intra-service time of 30 minutes and total time of 142 minutes). The RUC agreed that the work value of 5.93 appropriately accounts for the physician work involved in this service. The RUC noted that the survey code and crosswalk code 53852 have identical intra-service time and similar total time. The RUC agreed that an IWPUT of 0.088 is appropriate and that the recommended work value of 5.93 places the survey code well within the relativity of the entire family. Additionally, the RUC agreed that the recommended work value of 5.93 is appropriate because this (removal) service has a lower intensity, in comparison to the implantation and revision/replacement services in the family. **The RUC recommends an interim work RVU of 5.93 for CPT code 69726.**

69727 ***Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor***
The RUC reviewed the survey results from 59 physicians and determined that the work RVU of 7.13 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 45 minutes of intra-service time, 15 minutes of immediate post-service time, ½ discharge day management (99238), one office visit(s) (1x 99212), and one office visit(s) (1x 99213).

After thorough discussion, the RUC recommends a direct work RVU crosswalk to code 37718 *Ligation, division, and stripping, short saphenous vein* (work RVU = 7.13, intra-service time of 45 minutes and total time of 178 minutes). The RUC agreed that the crosswalk to code 37718 and recommended value of 7.13 appropriately accounts for the physician work involved in this service because the survey code and crosswalk code have identical intra-service time and similar total time. The RUC agreed that an IWPUT of 0.085 is appropriate and is like (removal) code 69726 (IWPUT = 0.088) in the family, therefore the recommended work value of 7.13 places the survey code well within the relativity of the entire family. Additionally, the RUC agreed that the recommended work value of 7.13 is appropriate because this (removal) service has a lower intensity, in comparison to the implantation and revision/replacement services in the family.

The RUC agreed that the recommended work value of 7.13 is appropriately bracketed by codes 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* (work RVU = 6.81, intra-service time of 45 minutes and total time of 161 minutes) and 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97, intra-service time of 45 minutes and total time of 185 minutes). **The RUC recommends an interim work RVU of 7.13 for CPT code 69727.**

Resurvey for April 2021 RUC Meeting
In January 2021, the RUC reviewed these services and determined that they need to be interim and resurveyed for the April 2021 RUC meeting with a revised Reference Service List (RSL) to encompass a larger range of relative values, specifically relative values on the lower end of the spectrum. Additionally, there was concern from the specialty that survey respondents may not have fully understood the new removal codes based on the anomalous intra-service time response for code 69726 which was less than all other codes in the family.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Practice Expense
The Practice Expense Subcommittee replaced one SA053 *pack, post-op incision care (suture and staple)* with one SA054 *pack, post-op incision care (suture)*. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

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

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Auditory System** **Middle Ear** **Osseointegrated Implants** The following codes are for implantation of an osseointegrated implant into the skull. These devices treat hearing loss through surgical placement of an abutment or device into the skull that facilitates transduction of acoustic energy to be received by the better-hearing inner ear or both inner ears when the implant is coupled to a speech processor and vibratory element. This coupling may occur in a percutaneous or a transcutaneous fashion. Other reparative middle ear and mastoid procedures (69501-69676) may be performed for different indications and may be reported separately when performed.				
▲69714	U1	Implantation, osseointegrated implant, ~~temporal bone~~ skull;~~,~~ with percutaneous attachment to external speech processor~~/cochlear stimulator; without mastoidectomy~~	090	8.69 (Interim) (Resurvey for April 2021)
●69716	U2	with magnetic transcutaneous attachment to external speech processor	090	9.77 (Interim) (Resurvey for April 2021)
~~69715~~	-	~~with mastoidectomy~~	~~090~~	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		(69715 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

▲69717	U3	Revision/~~R~~replacement (including removal of existing device), osseointegrated implant, ~~temporal bone,~~ skull; with percutaneous attachment to external speech processor~~/ cochlear stimulator; without mastoidectomy~~	090	8.80 (Interim) (Resurvey for April 2021)
●69719	U4	with magnetic transcutaneous attachment to external speech processor	090	9.77 (Interim) (Resurvey for April 2021)
~~69718~~	-	~~with mastoidectomy~~ (69718 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)	~~090~~	N/A
●69726	U5	Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	090	5.93 (Interim) (Resurvey for April 2021)
●69727	U6	with magnetic transcutaneous attachment to external speech processor	090	7.13 (Interim) (Resurvey for April 2021)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69714 Tracking Number Original Specialty Recommended RVU: **11.00**
Presented Recommended RVU: **8.69**
Global Period: 090 Current Work RVU: **14.45** RUC Recommended RVU: **8.69**

CPT Descriptor: Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old male suffers from chronic otitis media resulting in otorrhea and mixed hearing loss. He is unalbe to wear traditional hearing aids. Implantation of an osseointegrated bone anchored device with a percutaneous attachment to an external speech processor is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 49% , In the ASC 49%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed insertion site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection to the pericranium. A dissection is performed and the pericranium is incised and dissected away from the cranial bone to expose an area for implant placement. A pilot guide hole through the cranium is drilled, and the deep portion of the guide hole is instrumented to ascertain the possible presence of dural contact and lack of sigmoid sinus exposure. Depending on this deep instrumentation, the pilot hole is possibly deepened. The final guide hole is then widened with spiral drilling to achieve a larger opening to receive the implant. The implanted fixture is installed in the cranial bone to very specific torque settings. This implanted fixture is then secured to the transcutaneous abutment. The overlying flap and surrounding soft tissues are thinned to a maximal thickness to allow for transcutaneous attachment to the processor. A separate incision is made in the overlying skin of the flap to allow the percutaneous abutment to extend through the soft tissue flap. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion. A small bolster is created immediately surrounding the abutment and a locking cap is fixed to the abutment to keep the bolster in place and with appropriate pressure.

Description of Post-Service Work: The prepped area of the recipient site is cleaned. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The sutures are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The wound is again inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212
The patient's convalescence to that point is reviewed. The wounds are inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69714					
Sample Size:	533	**Resp N:**	73			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	3.00	**8.00**	12.00	45.00
Survey RVW:		1.00	11.00	**12.00**	14.00	17.40
Pre-Service Evaluation Time:				**34.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		10.00	25.00	**40.00**	46.00	155.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69714	**Recommended Physician Work RVU: 8.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**62.00**	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15120	090	10.15	**RUC Time**

CPT Descriptor Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31610	090	12.00	**RUC Time**

CPT Descriptor Tracheostomy, fenestration procedure with skin flaps

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	1,057,533

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

Other Reference CPT Code	Global	Work RVU	Time Source
66183	090	13.20	**RUC Time**

CPT Descriptor Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 **% of respondents:** 19.1 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 19.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 69714	Top Key Reference CPT Code: 15120	2nd Key Reference CPT Code: **31610**
Median Pre-Service Time	46.00	72.00	60.00
Median Intra-Service Time	40.00	75.00	45.00
Median Immediate Post-service Time	15.00	30.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	173.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	62.0	62.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**182.00**	**258.00**	**367.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	14%	36%	36%	14%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	21%	29%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	21%	36%	43%
Physical effort required	29%	36%	36%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	24%	43%	36%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	21%	50%	14%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	64%	21%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	21%	36%	43%
Physical effort required	31%	54%	16%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	42%	50%	8%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Note re: Key Reference Code #2

We recognize that KRS code 2, 31610, was selected as a KRS for this code, and some others in this family of codes by survey respondents. That code is marked "Do not use to value physician work" in the RUC database. The RUC database further states the following rationale: "The RUC recommends to flag CPT codes 31605 and 31610 as do not use for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 recommendation was based on the survey 75th percentile work RVU." We do not agree that simply because the 75th percentile was approved in valuing this service, that it should be viewed as unreliable as a comparison to other services, and therefore, we included it in our RSL as a recently valued, and familiar service that our members would understand.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **8.69 and 40 minutes of intra service time**, based on a crosswalk to CPT 52400. This is below the survey's 25th percentile.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that three post-operative office visits are typically conducted after the procedure. Two level three office visits, 99213; and one level two office visit, 99212.

Post op visit 1: 99213

The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The sutures are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The wound is again inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212
The patient's convalescence to that point is reviewed. The wounds are inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	090	0.06	6.39	40	187	2009-04	COLORECTAL SURGERY (PROCTOLOGY)	39
59870	Uterine evacuation and curettage for hydatidiform mole	090	0.0084	6.57	40	256	2000-08	OBSTETRICS/GYNECOLOGY	4
24358	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open	090	0.0669	6.66	40	193	2007-04	ORTHOPEDIC SURGERY	664
25109	Excision of tendon, forearm and/or wrist, flexor or extensor, each	090	0.0632	6.94	40	191	2006-04	HAND SURGERY	268
26715	Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed	090	0.0461	7.03	40	220	2007-02	ORTHOPEDIC SURGERY	216
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	090	0.0637	7.03	40	194	2011-04	ORTHOPEDIC SURGERY	51597
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive	090	0.126	8.69	40	197.5	2008-04	UROLOGY	115

	hypertrophic mucosal folds								

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 279
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume estimated below.

Specialty Otolaryngology Frequency 279 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 93 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The current 2019 volume indicated by the RUC database for this code is 993 cases, however, we anticipate the majority of this volume (94% or so) will transfer to the new X codes.

Specialty Otolaryngology Frequency 93 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 69714

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69716 Tracking Number Original Specialty Recommended RVU: **12.00**
Presented Recommended RVU: **9.77**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **9.77**

CPT Descriptor: Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male with left mixed hearing loss seeks intervention for improved quality of life at work and socially. Placement of a magnetic transcutaneous bone anchored heraing device is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 49% , In the ASC 49%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed insertion site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and a subpericranial pocket for the implant coil and magnet are created. The area for the transducer is then identified using the template and marked on the outer table of the skull in the region of the sinodural angle. Surgical guide and fixation holes are then drilled taking care not to penetrate the sigmoid sinus or the dura overlying the temporal lobe of the brain. This area is measured for appropriate depth to accommodate the fixation screw. The skull overlying the sinodural angle is then drilled to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura and sigmoid sinus. The entire device including the coil, magnet, and transducer portions are then placed. The device is then fixed to the skull using the fixation screw to a specific torque setting. The thickness of the flap overlying the magnet and coil portion of the device is then carefully measure and precisely trimmed to a specific thickness to allow for transcutaneous transmission. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69716					
Sample Size:	533	**Resp N:**	67			
Description of Sample:	Targeted, random survey of 533 otolaryngologist members of the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society)					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**4.00**	10.00	30.00
Survey RVW:		1.00	12.00	**13.00**	15.39	25.00
Pre-Service Evaluation Time:				**32.00**		
Pre-Service Positioning Time:				**10.00**		
Pre-Service Scrub, Dress, Wait Time:				**10.00**		
Intra-Service Time:		10.00	40.00	**60.00**	70.00	159.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69716	**Recommended Physician Work RVU: 9.77**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**32.00**	**33.00**	**-1.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31610	090	12.00	**RUC Time**

CPT Descriptor Tracheostomy, fenestration procedure with skin flaps

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15730	090	13.50	**RUC Time**

CPT Descriptor Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57288	090	12.13	**RUC Time**	25,452

CPT Descriptor 1 Sling operation for stress incontinence (eg, fascia or synthetic)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54437	090	11.50	**RUC Time**	54

CPT Descriptor 2 Repair of traumatic corporeal tear(s)

Other Reference CPT Code	Global	Work RVU	Time Source
27279	090	12.13	**RUC Time**

CPT Descriptor Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 6.0 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 8.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 69716	Top Key Reference CPT Code: 31610	2nd Key Reference CPT Code: **15730**
Median Pre-Service Time	45.00	60.00	58.00
Median Intra-Service Time	60.00	45.00	90.00
Median Immediate Post-service Time	15.00	20.00	17.50
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	173.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	46.0	69.00	71.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**185.00**	**367.00**	**255.50**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	8%	0%	58%	17%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	58%	34%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	42%	50%
Physical effort required	0%	75%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	42%	33%	25%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	33%	33%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	50%	33%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	50%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Note re: Key Reference Code #2

We recognize that KRS code 2, 31610, was selected as a KRS for this code, and some others in this family of codes by survey respondents. That code is marked "Do not use to value physician work" in the RUC database. The RUC database further states the following rationale: "The RUC recommends to flag CPT codes 31605 and 31610 as do not use for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 recommendation was based on the survey 75th percentile work RVU." We do not agree that simply because the 75th percentile was approved in valuing this service that it should be viewed as unreliable as a comparison to other services, and therefore, we included it in our RSL as a recently valued, and familiar service that our members would understand.

Recommendation (Work and Intra Time):

We are recommending a work RVU of **9.77 and 60 minutes of intra service time**, based on a crosswalk to CPT 50590. This is below our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 32 minutes of evaluation time which is 1 minute less than the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 45 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Regarding post-operative visits, our survey respondents indicated that two post-operative visits were needed, two 99213 visits. Our expert panel agreed.

Post op visit 1: 99213

The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	090	0.0523	9.56	60	275	2006-02	ORTHOPEDIC SURGERY	9419
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	090	0.0551	9.56	60	277	2015-04	ORTHOPEDIC SURGERY	1150
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	090	0.0485	9.58	60	254	2014-01	OPHTHALMOLOGY	594
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	090	0.0503	9.65	60	281	2007-02	ORTHOPEDIC SURGERY	242
29906	Arthroscopy, subtalar joint, surgical; with debridement	090	0.0662	9.65	60	244	2007-04	ORTHOPEDIC SURGERY	139
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	090	0.0507	9.67	60	281	2007-02	ORTHOPEDIC SURGERY	423
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	090	0.0357	9.71	60	308	2007-02	ORTHOPEDIC SURGERY	125
50590	Lithotripsy, extracorporeal shock wave	090	0.0908	9.77	60	207	2012-04	UROLOGY	54658
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	090	0.0613	9.78	60	262	2008-04	OTOLARYNGOLOGY	518
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	090	0.0533	9.90	60	281	2005-08	PLASTIC AND RECONSTRUCTIVE SURGERY	13549
24164	Removal of prosthesis, includes debridement and synovectomy when performed; radial head	090	0.0812	10.00	60	228	2013-01	ORTHOPEDIC SURGERY	103

57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	090	0.0965	10.08	60	211	2017-01	OBSTETRICS/GYNECOLOGY	9026
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	090	0.0965	10.08	60	211	2017-01	OBSTETRICS/GYNECOLOGY	8757
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	090	0.0934	10.13	60	216	2007-02	GENERAL SURGERY	62740
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	090	0.0947	10.13	60	218	2016-01	GENERAL SURGERY	28
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	090	0.0648	10.14	60	279	2007-04	ORTHOPEDIC SURGERY	208
23430	Tenodesis of long tendon of biceps	090	0.0842	10.17	60	237	2009-10	ORTHOPEDIC SURGERY	19997
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	090	0.0528	10.41	60	288	2005-08	DERMATOLOGY	13328
44950	Appendectomy;	090	0.0778	10.60	60	252	2000-08	GENERAL SURGERY	1101
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	090	0.0426	10.70	60	323	2007-02	ORTHOPEDIC SURGERY	1662
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	090	0.0198	10.78	60	384	2007-04	ORTHOPEDIC SURGERY	1248
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	090	0.0943	11.00	60	243	2009-04	NEUROSURGERY	2414
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	090	0.0484	11.10	60	328	2007-02	ORTHOPEDIC SURGERY	174
41120	Glossectomy; less than one-half tongue	090	0.0715	11.14	60	278	2005-08	OTOLARYNGOLOGY	2232
57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	090	0.0942	11.15	60	239	2010-10	OBSTETRICS/GYNECOLOGY	1737
65850	Trabeculotomy ab externo	090	0.1109	11.39	60	233	2005-08	OPHTHALMOLOGY	620
54437	Repair of traumatic corporeal tear(s)	090	0.0872	11.50	60	264	2015-01	UROLOGY	54
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	090	0.0923	11.60	60	267	2007-04	OBSTETRICS/GYNECOLOGY	986

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2979
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the 2019 volume for 69714 in the AMA RUC database

Specialty Otolaryngology Frequency 2979 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 900
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We believe the majority (94% or so) of existing volume for the predecessor code 69714 will move to this new code. Volume for 69714 in 2019 was 993 cases.

Specialty Otolarngology Frequency 900 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31070

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69717 Tracking Number Original Specialty Recommended RVU: **11.48**
Presented Recommended RVU: **8.80**
Global Period: 090 Current Work RVU: **15.43** RUC Recommended RVU: **8.80**

CPT Descriptor: Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old female with chronic otitis media and conductive hearing loss who previously received a percutaneous bone anchored implant has chronic inflammation at the abutment site that has been unresponsive to medical therapy. The device is removed and a new device is placed at a different site.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 48% , In the ASC 50%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential post-surgical skin breakdown and implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed insertion site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed implant recipient site is precisely measured and then marked using the implant template. The location of the implant transducer is marked using a hypodermic needle inserted down to the bone with marking ink, such as Methylene blue. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection to the pericranium. A subpericranial dissection is performed and the previous implant abutment is removed. The cranial bone surrounding the osseointegrated titanium fixture in the patient's skull is drilled around the implant. The fixture is removed. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The area for the new placement of the implant is then identified, templated, and marked on the outer table of the skull. A dissection is performed and the pericranium is incised and dissected away from the cranial bone to expose an area for implant placement. A new pilot guide hole through the cranium is drilled, and the deep portion of the guide hole is instrumented to ascertain the possible presence of dural contact and lack of sigmoid sinus exposure. Depending on this deep instrumentation, the pilot hole is possibly deepened. The final guide hole is then widened with spiral drilling to achieve a larger opening to receive the implant. The implanted fixture is installed in the cranial bone to very specific torque settings. This implanted fixture is then secured to the transcutaneous abutment. The overlying flap and surrounding soft tissues are thinned to a maximal

thickness to allow for transcutaneous attachment to the processor. A separate incision is made in the overlying skin of the flap to allow the percutaneous abutment to extend through the soft tissue flap. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion. A small bolster is created immediately surrounding the abutment and a locking cap is fixed to the abutment to keep the small abutment bolster in place and with appropriate pressure.

Description of Post-Service Work: he prepped area of the recipient site is cleaned. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The sutures are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The wound is again inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212
The patient's convalescence to that point is reviewed. The wounds are inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69717					
Sample Size:	533	**Resp N:**	64			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	2.00	10.00	
Survey RVW:	10.00	11.48	**12.50**	14.00	25.00	
Pre-Service Evaluation Time:			**37.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	10.00	30.00	**45.00**	60.00	201.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69717	**Recommended Physician Work RVU: 8.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	19.00	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	62.00	99211x **0.00** 12x **1.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15260	090	11.64	**RUC Time**

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15120	090	10.15	**RUC Time**

CPT Descriptor Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	1,057,533

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

Other Reference CPT Code	Global	Work RVU	Time Source
66183	090	13.20	**RUC Time**

CPT Descriptor Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 14.0 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 14.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 69717	Top Key Reference CPT Code: 15260	2nd Key Reference CPT Code: **15120**
Median Pre-Service Time	46.00	28.00	72.00
Median Intra-Service Time	45.00	100.00	75.00
Median Immediate Post-service Time	15.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	62.0	115.00	62.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**187.00**	**273.00**	**258.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	22%	67%	11%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	66%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	11%	22%	67%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	56%	44%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	11%	0%	33%	44%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	22%	33%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	33%	22%	44%
Physical effort required	44%	33%	22%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	33%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Recommendation (Work and Intra Time):

We are recommending a work RVU of **8.80 and 45 minutes of intra service time**, based on a crosswalk to CPT 27829. This is below our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that three post-operative office visits are typically conducted after the procedure. Three level three office visits, 99213. Our expert panel agreed that three visits are necessary, but amended them to two level three visits (99213) and one level two office visit (99212) consistent with code 69714.

Post op visit 1: 99213
The mastoid dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability is assessed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The small abutment bolster and associated locking cap device are removed. The sutures are removed. The area around the percutaneous abutment is vigorously cleaned and possibly debrided. The wound is again inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212
The patient's convalescence to that point is reviewed. The wounds are inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization	2019 Medicare Allowed Charges
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	090	0.0761	8.13	45	209	2009-02	COLORECTAL SURGERY (PROCTOLOGY)	2516	1560949
52500	Transurethral resection of bladder neck (separate procedure)	090	0.0582	8.14	45	230.5	2008-04	UROLOGY	3173	1544895
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	0.0419	8.31	45	260	2006-02	ORTHOPEDIC SURGERY	2015	1262949
67255	Scleral reinforcement (separate procedure); with graft	090	0.0595	8.38	45	216	2014-01	OPHTHALMOLOGY	833	430830
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	090	0.0511	8.56	45	255	2005-08	GENERAL SURGERY	199	110926
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	0.0457	8.80	45	271	2007-02	ORTHOPEDIC SURGERY	7628	3853250
31610	Tracheostomy, fenestration procedure with skin flaps	090	0.0278	12.00	45	367	2016-10	OTOLARYNGOLOGY	1593	1406921
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	090	0.126	13.20	45	257	2013-04	OPHTHALMOLOGY	4674	4894644
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	090	0.1293	13.94	45	278	2015-04	OPHTHALMOLOGY	6957	7907614

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69717

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 18
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume estimated below.

Specialty Otolaryngology Frequency 18 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The current 2019 volume indicated by the RUC database for this code is 68, however, we esitmate that only about 7% of existing cases will be reported in the future by the percutaneous codes. We anticipate that the remainder of the volume will transition to the new transcutaneous codes.

Specialty Otolaryngology Frequency 6 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 69717

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69719 Tracking Number Original Specialty Recommended RVU: **12.00**
Presented Recommended RVU: **9.77**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **9.77**

CPT Descriptor: Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old female with right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant. It worked well, but she has developed discomfort at the device site. The device is removed and a new device is placed at a different site.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 47% , In the ASC 51%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Review the CT scan to ensure that there is adequate bone quality and quantity in the area of implantation to support a successful implantation. Perform a current physical exam paying special attention to the patient's skin condition and skin thickness in the area of the actuator and coil to avoid potential repeat post-surgical skin breakdown, pain, and possible implant extrusion. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed insertion site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the proposed NEW implant recipient site is precisely measured and then marked using the implant template. The incision is injected with local anesthetic

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is removed. The wound is thoroughly inspect for the cause of the patient's original complication related to the implant. A subpericranial pocket for the implant coil and magnet are created. The area for the new placement of the transducer is then identified using the template and marked on the outer table of the skull. Surgical guide and fixation holes are then drilled taking care not to penetrate the dura overlying the temporal lobe of the brain. This area is measured for appropriate depth to accommodate the fixation screw. The skull is then drilled to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura. The entire device including the coil, magnet, and transducer portions are then placed. The device is then fixed to the skull using the fixation screw to a specific torque setting. The thickness of the flap overlying the magnet and coil portion of the device is then carefully measure and precisely trimmed to a specific thickness to allow for transcutaneous transmission. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69719					
Sample Size:	533	**Resp N:**	59			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	2.00	10.00	
Survey RVW:	10.15	12.00	**13.00**	15.48	27.00	
Pre-Service Evaluation Time:			**37.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	14.00	43.00	**60.00**	80.00	201.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69719	**Recommended Physician Work RVU: 9.77**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**46.00**	99211x **0.00** 12x **0.00** 13x **2.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
31610	090	12.00	**RUC Time**

CPT Descriptor Tracheostomy, fenestration procedure with skin flaps

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15730	090	13.50	**RUC Time**

CPT Descriptor Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57288	090	12.13	**RUC Time**	25,452

CPT Descriptor 1 Sling operation for stress incontinence (eg, fascia or synthetic)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
54437	090	11.50	**RUC Time**	54

CPT Descriptor 2 Repair of traumatic corporeal tear(s)

Other Reference CPT Code	Global	Work RVU	Time Source
27279	090	12.13	**RUC Time**

CPT Descriptor Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 13.5 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 11.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 69719	Top Key Reference CPT Code: 31610	2nd Key Reference CPT Code: **15730**
Median Pre-Service Time	46.00	60.00	58.00
Median Intra-Service Time	60.00	45.00	90.00
Median Immediate Post-service Time	15.00	20.00	17.50
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	173.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	46.0	69.00	71.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**186.00**	**367.00**	**255.50**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	38%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	63%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	13%	88%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	75%	13%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	57%	14%	29%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	57%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	57%	43%
Physical effort required	0%	71%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	29%	43%	29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Note re: Key Reference Code #1

We recognize that KRS code 1, 31610, was selected as a KRS for this code, and some others in this family of codes by survey respondents. That code is marked "Do not use to value physician work" in the RUC database. The RUC database further states the following rationale: "The RUC recommends to flag CPT codes 31605 and 31610 as do not use for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 recommendation was based on the survey 75th percentile work RVU." We do not agree that simply because the 75th percentile was approved in valuing this service that it should be viewed as unreliable as a comparison to other services, and therefore, we included it in our RSL as a recently valued, and familiar service that our members would understand.

Recommendation (Work and Intra Time):

We are recommending a work RVU of 9.77 **and 60 minutes of intra service time**, based on a crosswalk to CPT 50590. This is below our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. Two level three office visits, 99213.

Post op visit 1: 99213

The dressing is removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. Flap viability overlying the coil is assessed. The sutures are removed. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. Antibiotic ointment is placed on the surgical wound.

Post op visit 2: 99213
The patient's convalescence to that point is reviewed. The wound is inspected and palpated for full incisional healing prior to fitting the sound processor. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Long term care, strategies to maximize function, and expected outcomes are discussed in detail. Counseling regarding the device, its function, and signs and symptoms of trouble with the device are discussed with the patient and family.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	090	0.0523	9.56	60	275	2006-02	ORTHOPEDIC SURGERY	9419
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon	090	0.0551	9.56	60	277	2015-04	ORTHOPEDIC SURGERY	1150
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	090	0.0485	9.58	60	254	2014-01	OPHTHALMOLOGY	594
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed	090	0.0503	9.65	60	281	2007-02	ORTHOPEDIC SURGERY	242
29906	Arthroscopy, subtalar joint, surgical; with debridement	090	0.0662	9.65	60	244	2007-04	ORTHOPEDIC SURGERY	139
27784	Open treatment of proximal fibula or shaft fracture, includes internal fixation, when performed	090	0.0507	9.67	60	281	2007-02	ORTHOPEDIC SURGERY	423
24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	090	0.0357	9.71	60	308	2007-02	ORTHOPEDIC SURGERY	125
50590	Lithotripsy, extracorporeal shock wave	090	0.0908	9.77	60	207	2012-04	UROLOGY	54658
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	090	0.0613	9.78	60	262	2008-04	OTOLARYNGOLOGY	518
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	090	0.0533	9.90	60	281	2005-08	PLASTIC AND RECONSTRUCTIVE SURGERY	13549
24164	Removal of prosthesis, includes debridement and synovectomy when performed; radial head	090	0.0812	10.00	60	228	2013-01	ORTHOPEDIC SURGERY	103

57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	090	0.0965	10.08	60	211	2017-01	OBSTETRICS/GYNECOLOGY	9026
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	090	0.0965	10.08	60	211	2017-01	OBSTETRICS/GYNECOLOGY	8757
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	090	0.0934	10.13	60	216	2007-02	GENERAL SURGERY	62740
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	090	0.0947	10.13	60	218	2016-01	GENERAL SURGERY	28
27769	Open treatment of posterior malleolus fracture, includes internal fixation, when performed	090	0.0648	10.14	60	279	2007-04	ORTHOPEDIC SURGERY	208
23430	Tenodesis of long tendon of biceps	090	0.0842	10.17	60	237	2009-10	ORTHOPEDIC SURGERY	19997
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	090	0.0528	10.41	60	288	2005-08	DERMATOLOGY	13328
44950	Appendectomy;	090	0.0778	10.60	60	252	2000-08	GENERAL SURGERY	1101
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed	090	0.0426	10.70	60	323	2007-02	ORTHOPEDIC SURGERY	1662
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	090	0.0198	10.78	60	384	2007-04	ORTHOPEDIC SURGERY	1248
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	090	0.0943	11.00	60	243	2009-04	NEUROSURGERY	2414
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), with internal fixation, when performed; of fibula only	090	0.0484	11.10	60	328	2007-02	ORTHOPEDIC SURGERY	174
41120	Glossectomy; less than one-half tongue	090	0.0715	11.14	60	278	2005-08	OTOLARYNGOLOGY	2232
57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	090	0.0942	11.15	60	239	2010-10	OBSTETRICS/GYNECOLOGY	1737
65850	Trabeculotomy ab externo	090	0.1109	11.39	60	233	2005-08	OPHTHALMOLOGY	620
54437	Repair of traumatic corporeal tear(s)	090	0.0872	11.50	60	264	2015-01	UROLOGY	54
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	090	0.0923	11.60	60	267	2007-04	OBSTETRICS/GYNECOLOGY	986

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 27
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the estimated Medicare volume cited below

Specialty Otolaryngology Frequency 27 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Industry data indicates that approximately .5-1% of cases of 69716 will be revised, we estimate 900 cases per year of 69716, and 9 is 1% of that volume.

Specialty Otolaryngology Frequency 9 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31070

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69726 Tracking Number Original Specialty Recommended RVU: **10.00**
Presented Recommended RVU: **5.93**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **5.93**

CPT Descriptor: Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old female with a right mixed hearing loss had previous placement of a percutaneous bone anchored implant. It worked well, but she has developed discomfort at the device site. The device is removed without replacement.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 33% , In the ASC 36%, In the office 30%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam paying special attention to the patient's skin condition adequacy for closure following implant removal. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed removal site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the incision is marked in the region of the previous incision. The incision is injected with local anesthetic.

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseo-integrated titanium fixture in the patient's skull is drilled around the implant. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The wound is irrigated and hemostasis is obtained. The wound where the external abutment of the implant is debrided then closed followed by closure of the linear incision anterior to the implant site in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other

complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The incisions and wound are inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99212
The patient's convalescence to that point is reviewed. The wound is again inspected and palpated to insure full healing. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69726					
Sample Size:	533	**Resp N:**	66			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	2.00	10.00	
Survey RVW:	5.00	10.00	**10.90**	12.00	20.45	
Pre-Service Evaluation Time:			**32.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	5.00	20.00	**30.00**	45.00	187.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69726	**Recommended Physician Work RVU: 5.93**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**32.00**	**33.00**	**-1.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	19.00	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	39.00	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15120	090	10.15	**RUC Time**

CPT Descriptor Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
66185	090	10.58	**RUC Time**

CPT Descriptor Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
26615	090	7.07	**RUC Time**	1,057,533

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

Other Reference CPT Code	Global	Work RVU	Time Source
27829	090	8.80	**RUC Time**

CPT Descriptor Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 **% of respondents:** 43.9 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 69726	Top Key Reference CPT Code: 15120	2nd Key Reference CPT Code: **66185**
Median Pre-Service Time	45.00	72.00	25.00
Median Intra-Service Time	30.00	75.00	65.00
Median Immediate Post-service Time	15.00	30.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	39.0	62.00	140.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**148.00**	**258.00**	**259.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	7%	31%	48%	14%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	31%	41%	28%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	45%	31%	24%
Physical effort required	34%	38%	27%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	44%	48%	6%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	63%	38%	0%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	26%	63%	13%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	63%	38%	0%
Physical effort required	50%	50%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	38%	62%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Recommendation (Work and Intra Time):

We are recommending a work RVU of **5.93 and 30 minutes of intra service time**, based on a crosswalk to CPT 53852. This is below our survey's 25th percentile RVW and utilizes our survey's median intra-service time.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 32 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 45 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. One level three office visit, 99213; and one level two office visit, 99212. Our expert panel agreed.

Post op visit 1: 99213
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The incisions and wound are inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99212
The patient's convalescence to that point is reviewed. The wound is again inspected and palpated to insure full healing. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
46262	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	090	0.0888	7.91	45	179	2000	General Surgery	106
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	090	0.0892	7.97	45	185	2005	Ophthalmology	54853
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	090	0.0761	8.13	45	209	2009-02	COLORECTAL SURGERY (PROCTOLOGY)	2516
52500	Transurethral resection of bladder neck (separate procedure)	090	0.0582	8.14	45	230.5	2008-04	UROLOGY	3173
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	0.0419	8.31	45	260	2006-02	ORTHOPEDIC SURGERY	2015
67255	Scleral reinforcement (separate procedure); with graft	090	0.0595	8.38	45	216	2014-01	OPHTHALMOLOGY	833
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	090	0.0511	8.56	45	255	2005-08	GENERAL SURGERY	199
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	0.0457	8.80	45	271	2007-02	ORTHOPEDIC SURGERY	7628
31610	Tracheostomy, fenestration procedure with skin flaps	090	0.0278	12.00	45	367	2016-10	OTOLARYNGOLOGY	1593
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	090	0.126	13.20	45	257	2013-04	OPHTHALMOLOGY	4674
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	090	0.1293	13.94	45	278	2015-04	OPHTHALMOLOGY	6957

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the estimated Medicare data below.

Specialty Otolaryngology Frequency 3 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that 1% of future 69714 volume will have to be removed. The 2019 volume of 69714 was 993 cases, which we anticipate will drop approximately 94% to 93 cases going forward. One percent of 93 is .93, or one case per year.

Specialty Otolaryngology Frequency 1 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31070

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:69727 Tracking Number Original Specialty Recommended RVU: **10.98**
Presented Recommended RVU: **7.13**
Global Period: 090 Current Work RVU: RUC Recommended RVU: **7.13**

CPT Descriptor: Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male with right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant which worked well, but has now become infected. The device is removed without replacement.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 46% , In the ASC 51%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Meet with patient and family to describe and discuss in detail the planned procedure. Review and update the medical history. Perform a current physical exam paying special attention to the patient's skin condition adequacy for closure following implant removal. Reconcile medications and allergies. Address NPO status and timing. Discuss preoperative home medications and postoperative prescriptions and check the prescription drug monitoring database, discuss. Plan the patient's expected convalescence and educate the patient and caregivers regarding the signs and symptoms of the most common and serious complications. There is confirmation of site of proposed removal site, and a detailed description is given of the postoperative changes in wound and incision and the expected cosmetic and functional results. Review and obtain informed consent. Verify that all required instruments and supplies are available. Following induction of anesthesia, the patient is positioned and prepped for the procedure. A timeout is performed with entire surgical team, including confirmation of the procedure, locations, allergies, antibiotic prophylaxis, anesthesia and fire risks, expected duration, and any concerns related to the procedure. The postauricular hair is shaved and the incision is marked

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection through the pericranium. A subpericranial dissection is performed and the previous implant is exposed. The cranial bone surrounding the osseo-integrated titanium transducer and the respective fixture screws in the patient's skull is drilled out to free the implant. The wound is thoroughly inspected for the cause of the patient's original complication related to the implant. The wound is irrigated and hemostasis is obtained. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site. The patient is observed during emergence from anesthesia. Dictation and postoperative orders are performed. Discharge medications are reconciled and prescriptions are written. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team. Communication with the referring physician is then performed. There is a discussion with the family regarding the procedure and findings. The patient is then seen after emergence from general anesthesia to check the patient's neurologic status, wound for signs of hematoma, or other complications. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications, and review the written postoperative instructions.

Post op visit 1: 99213
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99212
The patient's convalescence to that point is reviewed. The wound is again inspected and palpated to insure full healing. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	R. Peter Manes, MD					
Specialty Society(ies):	AAO-HNS					
CPT Code:	69727					
Sample Size:	533	**Resp N:**	59			
Description of Sample:	Targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**0.00**	1.00	10.00	
Survey RVW:	5.00	10.98	**12.00**	12.75	28.00	
Pre-Service Evaluation Time:			**36.00**			
Pre-Service Positioning Time:			**10.00**			
Pre-Service Scrub, Dress, Wait Time:			**10.00**			
Intra-Service Time:	12.00	30.00	**45.00**	60.00	164.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	69727	**Recommended Physician Work RVU: 7.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**10.00**	**15.00**	**-5.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9A General Anes or Complex Reg Blk/Strghtforw Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**30.00**	**-15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
15120	090	10.15	**RUC Time**

CPT Descriptor Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
41120	090	11.14	**RUC Time**

CPT Descriptor Glossectomy; less than one-half tongue

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	54,853

CPT Descriptor 1 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
28003	090	9.06	**RUC Time**	5,470

CPT Descriptor 2 Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas

Other Reference CPT Code	Global	Work RVU	Time Source
51647	090	11.30	**RUC Time**

CPT Descriptor Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 22.0 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 13.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 69727	Top Key Reference CPT Code: 15120	2nd Key Reference CPT Code: **41120**
Median Pre-Service Time	46.00	72.00	60.00
Median Intra-Service Time	45.00	75.00	60.00
Median Immediate Post-service Time	15.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	19.0	0.00	0.00
Median Office Visit Time	39.0	62.00	109.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**164.00**	**258.00**	**278.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	38%	38%	23%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	46%	39%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	46%	15%	38%
Physical effort required	38%	38%	23%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	31%	46%	23%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	38%	50%	13%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	50%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	38%	50%	12%
Physical effort required	38%	50%	12%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	63%	38%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2020, the Academy brought forward a Code Change Application requesting the revision of two existing codes, 69714 and 69717, as well as the addition of four new codes 69716-727. These new codes represent implantation, revision/replacement, and removal of a transcutaneous and percutaneous osseointegrated implants, respectively. The

Panel approved the CCA and the code is now being valued by the RUC. The new codes will be published in the 2022 edition of the CPT Book.

Survey Sample and Process:

A survey request was sent to a targeted, random selection of 533 members from the AAO-HNS, the American Neurotology Society, and the AOS (American Otological Society).

Recommendation (Work and Intra Time):

We are recommending a work RVU of **7.13 and 45 minutes of intra service time**, based on a crosswalk to CPT 37718. This is below our survey's 25th percentile RVW.

Time package selection: We have selected pre-time package 3 and post-time package 9A due to this procedure currently being done predominantly in the hospital outpatient setting under general anesthesia.

Pre-time Package 3 Straightforward Patient/Difficult Procedure

Evaluation Time – We are recommending 33 minutes of evaluation time which is identical to the pre-service package time, based on our survey median.

Positioning Time – We are recommending 3 minutes of positioning time which is 7 minutes less than the survey median time, but consistent with the preservice package.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is 5 minutes less than the pre-service package time, based on our survey median.

This results in a total recommended pre time of 46 minutes, taking the lesser of surveyed time or the pre-service package time.

Post-time Package 9A General Anesthesia or Complex Regional Block/ Straightforward Procedure
Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected to match our survey time. ***This results in a total recommended post time of 15 minutes, taking the lesser of surveyed time or the pre-service package time.***

Discharge Management / Post-Operative Visits
Given that this procedure is almost exclusively performed in the hospital outpatient or ASC setting, and general anesthesia sedation is utilized, patients must be monitored closely following the procedure. This results in a discharge management visit being performed after the procedure, before the patient is discharged from the hospital. Our survey did not indicate that this was typical, however, it is the RUC standard for 090 global services when performed in the hospital, so we have included **.5 discharge management visit in our recommendations for this CPT code.**

Survey respondents also indicated that two post-operative office visits are typically conducted after the procedure. One level three office visit, 99213 and one level two office visit, 99212.Our expert panel agreed.

Post op visit 1: 99213
The mastoid dressing is removed. The sutures are removed. The patient's convalescence to that point is reviewed and discussed. The neurological status is assessed. The wound is inspected and palpated. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Antibiotic ointment is placed on the wound. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 2: 99212
The patient's convalescence to that point is reviewed. The wound is again inspected and palpated to insure full healing. The middle ear is inspected. Tuning forks are utilized to evaluate the patients hearing. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A discussion occurs regarding different hearing options now that the previous osseointegrated implant has been removed and not replaced.

Supporting Reference Codes for the Recommended Value

CPT Code	Long Desc	Global	IWPUT	Work RVU	Intra Time	Total Time	Most Recent RUC Review	Top_Specialty	2019 Medicare Utilization
46262	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed	090	0.0888	7.91	45	179	2000	General Surgery	106
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	090	0.0892	7.97	45	185	2005	Ophthalmology	54853
45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	090	0.0761	8.13	45	209	2009-02	COLORECTAL SURGERY (PROCTOLOGY)	2516
52500	Transurethral resection of bladder neck (separate procedure)	090	0.0582	8.14	45	230.5	2008-04	UROLOGY	3173
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	0.0419	8.31	45	260	2006-02	ORTHOPEDIC SURGERY	2015
67255	Scleral reinforcement (separate procedure); with graft	090	0.0595	8.38	45	216	2014-01	OPHTHALMOLOGY	833
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	090	0.0511	8.56	45	255	2005-08	GENERAL SURGERY	199
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed	090	0.0457	8.80	45	271	2007-02	ORTHOPEDIC SURGERY	7628
31610	Tracheostomy, fenestration procedure with skin flaps	090	0.0278	12.00	45	367	2016-10	OTOLARYNGOLOGY	1593
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	090	0.126	13.20	45	257	2013-04	OPHTHALMOLOGY	4674
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	090	0.1293	13.94	45	278	2015-04	OPHTHALMOLOGY	6957

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 69714

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otoloaryngology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 27
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the estimated Medicare volume cited below.

Specialty Otolaryngology Frequency 27 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Industry data estimates .5-1% of 69716 cases will have to be removed. We estimated 900 cases per year of 69716, and 1% of that is 9.

Specialty Otolaryngology Frequency 9 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 31070

SS Rec Summary

ISSUE: Transcutaneous Passive Implant Temporal Bone (BAHA)

TAB: 18

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POST	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-input/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	15120	90	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and	14	0.068	0.039			10.15			258	40	12	20			75			30						0.5		2	1							
2nd REF	31610	90	Tracheostomy, fenestration procedure with skin flaps	14	0.028	0.033			12.00			367	40	10	10			45			20		1	1	2		1.0		3								
CURRENT	69714	90	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy		0.098	0.051			14.45			284	55					90			30						1.0		1	3							
SVY	69714		Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	73	0.188	0.063	1.00	11.00	12.00	14.00	17.40	190	34	10	10	10	25	40	46	155	15						0.5		2	1			0	3	8	12	45
W/ EXP				69	0.194	0.063	1.00	11.00	12.00	14.00	17.40	189	35	10	10	10	25	40	45	155	32						2	1					1	5	8	13	45
W/OUT EXP				4	0.188	0.067	1.00	10.39	10.88	11.74	13.20	162	29	9	20	20	24	42	67	90	23								1	1							
CROSSWALK	52400	90	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral		0.126	0.044			8.69			198	72.5	10	15			40			25						0.5			1							
REC	69714	90	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor		0.110	0.048			8.69			182	33	3	10			40			15						0.5		2	1							
1st REF	31610	90	Tracheostomy, fenestration procedure with skin flaps	12	0.028	0.033			12.00			367	40	10	10			45			20		1	1	2		1.0		3								
2nd REF	15730	90	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	6	0.100	0.053			13.50			256	40	3	15			90			17.5						0.5		1	3							
CURRENT	NEW				#DIV/0!	#DIV/0!																															
SVY	69716		Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to	67	0.151	0.068	1.00	12.00	13.00	15.39	25.00	192	32	10	10	10	40	60	70	159	15						0.5		2				0	2	4	10	30
W/ EXP				58	0.183	0.070	1.00	12.00	13.13	15.68	25.00	187	35	10	10	10	40	48	60	159	15								3				1	3	5	10	30
W/OUT EXP				9	0.141	0.064	10.50	11.25	12.00	12.50	17.40	187	40	15	10	20	45	65	90	150	25									2							
CROSSWALK	50590	90	Lithotripsy, extracorporeal shock wave		0.091	0.047			9.77			207	33	3	15			60			15						0.5		2	1							
REC	69716	90	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		0.100	0.053			9.77			185	32	3	10			60			15						0.5		2								
1st REF	15260	90	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids,	9	0.056	0.043			11.64			273	17	1	10			100			30								5								
2nd REF	15120	90	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands,	9	0.068	0.039			10.15			258	40	12	20			75			30						0.5		2	1							
CURRENT	69717	90	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear		0.105	0.055			15.43			282	50					95			28						1.0		1	3							
SVY	69717		Revision/replacement (including removal of existing device), osseointegrated implant,	64	0.166	0.061	10.00	11.48	12.50	14.00	25.00	205	37	10	10	10	30	45	60	201	15						0.5		3				0	0	1	2	10
W/ EXP				40	0.200	0.071	10.00	11.69	13.00	16.25	25.00	183	40	11	10	10	30	45	60	201	15								2	1			1	1	2	3	10
W/OUT EXP				24	0.225	0.077	10.00	11.12	12.00	13.62	17.30	155	37	10	11	15	30	40	60	120	18								1	1							
CROSSWALK	27829	90	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed		0.046	0.032			8.80			271	45	10	15			45			20				1		1.0		2	2							
REC	69717	90	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor		0.100	0.047			8.80			187	33	3	10			45			15						0.5		2	1							
1st REF	31610	90	Tracheostomy, fenestration procedure with skin flaps	8	0.028	0.033			12.00			367	40	10	10			45			20		1	1	2		1.0		3								
2nd REF	15730	90	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	7	0.100	0.053			13.50			256	40	3	15			90			17.5						0.5		1	3							
CURRENT	NEW	90			#DIV/0!	#DIV/0!						0																									
SVY	69719		Revision/replacement (including removal of existing device), osseointegrated implant,	59	0.149	0.066	10.14	12.00	13.00	15.48	27.00	197	37	10	10	14	43	60	80	201	15						0.5		2				0	0	1	2	10
W/ EXP				31	0.167	0.073	10.15	12.04	13.60	16.67	27.00	186	35	15	10	24	45	60	90	201	20								2				1	1	2	3	10
W/OUT EXP					0.164	0.073	10.50	12.00	12.85	14.56	20.00	175	40	10	11	14	30	60	75	120	15								1	1							
CROSSWALK	50590	90	Lithotripsy, extracorporeal shock wave		0.091	0.047			9.77			207	33	3	15			60			15						0.5		2	1							
REC	69719	90	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		0.099	0.053			9.77			186	33	3	10			60			15						0.5		2								
1st REF	15120	90	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands,	29	0.068	0.039			10.15			258	40	12	20			75			30						0.5		2	1							
2nd REF	66185	90	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	8	0.060	0.041			10.58			259	19	1	5			65			10						0.5		4	3							
CURRENT	NEW	90			#DIV/0!	#DIV/0!						0																									
SVY	69726		Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	66	0.248	0.070	5.00	10.00	10.90	12.00	20.45	155	32	10	10	5	20	30	45	187	15						0.5		1	1			0	0	1	2	10
W/ EXP				48	0.277	0.081	5.00	10.00	10.69	12.24	20.45	132	35	10	10	5	20	30	45	128	15									2			1	1	2	3	10
W/OUT EXP				18	0.265	0.074	8.00	10.04	11.07	11.89	14.50	150	35	15	11	5	21	30	45	187	20								1	1							
CROSSWALK	53852	90	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy		0.071	0.042			5.93			142	17	6	5			30			15								3								
REC	69726	90	Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor		0.088	0.040			5.93			148	32	3	10			30			15						0.5		1	1							
1st REF	15120	90	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands,	13	0.068	0.039			10.15			258	40	12	20			75			30						0.5		2	1							
2nd REF	41120	90	Glossectomy; less than one-half tongue	8	0.071	0.040			11.14			278	30	15	15			60			30						0.5		1	3							
CURRENT	NEW	90			#DIV/0!	#DIV/0!						0																									
SVY	69727		Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to	59	0.188	0.069	5.00	10.98	12.00	12.75	28.00	174	36	10	10	12	30	45	60	164	15						0.5		1	1			0	0	0	1	10
W/ EXP				27	0.179	0.066	10.00	11.27	12.00	14.00	28.00	182	35	10	10	12	30	45	60	164	20								2	1			1	1	1	2	10
W/OUT EXP				32	0.271	0.091	5.00	10.75	11.50	12.13	25.00	127	40	10	11	14	23	35	53	120	15									1							
CROSSWALK	37718	90	Ligation, division, and stripping, short saphenous vein		0.078	0.040			7.13			178	35	10	10			45			20						0.5		1	1							
REC	69727	90	Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		0.085	0.043			7.13			164	33	3	10			45			15						0.5		1	1							

FACILITY DIRECT PE INPUTS **CPT CODE(S):_69714, 69717, 69716-27_____**

SPECIALTY SOCIETY(IES):_AAO-HNS_____

PRESENTER(S):_R. Peter Manes, MD_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
69714	Implantation, osseointegrated implant, skull;, with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69717	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69719	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69726	Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor	090
CPT Code	**Long Descriptor**	**Global Period**
69727	Removal, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor	090

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
69714	A 56-year-old male suffers from chronic otitis media resulting in otorrhea and mixed hearing loss. He is unable to wear traditional hearing aids. Implantation of an osseointegrated bone anchored device with a percutaneous attachment to an external speech processor is performed.
CPT Code	**Vignette**
69716	A 48-year-old male with a left mixed hearing loss seeks intervention for improved quality of life at work and socially. Placement of a magnetic transcutaneous bone anchored hearing device is performed.
CPT Code	**Vignette**

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

69717	A 16-year-old female with chronic otitis media and conductive hearing loss who previously received a percutaneous bone anchored implant has chronic inflammation at the abutment site that has been unresponsive to medical therapy. The device is removed and a new device is placed at a different site.
CPT Code	**Vignette**
69719	A 59-year-old female with a right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant. It worked well, but she has developed discomfort at the device site. The device is removed and a new device is placed at a different site.
CPT Code	**Vignette**
69726	A 59-year-old female with a right mixed hearing loss had previous placement of a percutaneous bone anchored implant. It worked well, but she has developed discomfort at the device site. The device is removed without replacement.
CPT Code	**Vignette**
69727	A 62-year-old male with a right mixed hearing loss previously had placement of a magnetic transcutaneous bone anchored implant which worked well, but has now become infected. The device is removed without replacement.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialty formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisor and multiple clinical experts who practice in the areas of general otolaryngology, sleep medicine, and otology. The expert panel members also practice across in settings that vary by size, geography, and represent both private and academic settings.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing codes 69714 and 69717 were utilized as comparison codes for all new codes in the family.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence*

guidelines) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

During the pre-service clinical staff are completing pre-service diagnostic and referral forms, coordinating pre-surgery services including test results, scheduling space and equipment in the facility, providing pre-service education and obtaining consent from the patient, and completing pre-procedure phone calls and prescriptions.

   b. Service period (includes pre, intra and post):

During the service period the clinical staff assist with a half discharge management visit for the patient. This includes post-procedure care instructions. They also clean the instruments used during each post operative visit.

   c. Post-service period:

During post operative visits the patient is checked in via front-desk staff. Clinical staff collects vitals from the patient. An exam chair/table and light are required with paper covering for the exam furniture. A postoperative wound kit for removal of sutures/staples is required. The clinical staff assists the physician with removal of the sutures.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, minimum multi-specialty visit	**SA048**	**pack**		**4.0507**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, cleaning, surgical instruments	**SA043**	**pack**	1	**10.7922**
gloves, non-sterile		pair	2	
gown, staff, impervious		item	1	
face shield, splash protection		item	1	
autoclave bag		item	1	
autoclave tape		yd	0.33	
enzymatic detergent		oz	1	
cleaning brush, instruments		item	1	

DESCRIPTION	Code	Unit
pack, post-op incision care (suture)	**SA054**	**pack**
kit, suture removal		kit
povidone soln (Betadine)		ml
gauze, sterile 4in x 4in		item
gloves, sterile		pair
steri-strip (6 strip uou)		item
swab-pad, alcohol		item
tape, surgical paper 1in (Micropore)		inch
tincture of benzoin, swab		item

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

16. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EQ234 suction and pressure cabinet, ENT (SMR)
EQ183 microscope, operating
EQ170 light, fiberoptic headlight w-source
EF008 chair with headrest, exam, reclining

The office visit formula was used for all these pieces of equipment.

EQ137 basic instrument pack

The instrument pack formula was used for this item.

17. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

18. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is

reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

Clinical staff time in the preservice period remains unchanged for all codes in the family. All codes have cleaning time added in the intra service time period to allocate time to cleaning the instruments used at each post op visit. Post-operative time has changed, commensurate with the survey data and recommended post op visits. Two codes (64714/64717) have 3 post op visits and the rest of the family has 2 post op visits.

Some supplies were reduced commensurate with reducing the post-operative visits per our survey data. Additionally, we added a minimum multi-specialty pack for each post op visit and reduced individual, unnecessary line items. We also added a basic instrument pack and cleaning pack for the instruments which will be used at each post op visit. The items include a tuning fork, Frasier tip suctions, and ear curettes. We removed the suture/staple pack and replaced it with just a suture pack.

Equipment times were reduced based on less office visits and lower overall office visit post time. The instrument pack formula was used for the new instrument pack and cleaning time was accounted for.

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**REFE**
2						**CPT Code 69714**		**CPT Code 69714**		**CPT Co**
3		***RUC Collaboration Website***				Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to		Implantation, osseointegrated implant, skull;, with percutaneous attachment to external speech processor		Implan osseoin implant, bone percut attach
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 18 Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 225.41**	**$ -**	**$ 138.38**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**183.0**	**0.0**	**204.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**6.0**	**0.0**	**36.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ 67.71**	**$ -**	**$ 75.48**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		5		5	
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		20		20	
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		8		8	
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37		20		20	
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		7		7	
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37					
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37					
23			L037D	RN/LPN/MTA	0.37					
26		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37					
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37					
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37					
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37					
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37					
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37					
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37					
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37					
42			L037D	RN/LPN/MTA	0.37					
45		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
48		**Intra-service (of service period)**								
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (33%)	L037D	RN/LPN/MTA	0.37					
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (66%)	L037D	RN/LPN/MTA	0.37					
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)	L037D	RN/LPN/MTA	0.37					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37					
55			L037D	RN/LPN/MTA	0.37					
56		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37					
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37					
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37					
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37					
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37				30	
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37					
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37					
68	CA030	Technologist QCs images in PACS, checking for all images, reformats, and dose page	L037D	RN/LPN/MTA	0.37					
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	L037D	RN/LPN/MTA	0.37					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37					
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, ESRD flow sheet)	L037D	RN/LPN/MTA	0.37					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37					
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**	**6**	**n/a**	**6**	**n/a**
75			L037D	RN/LPN/MTA	0.37					
78		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37					
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37					
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27				3			
89		99213 36 minutes	36				1		3	
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37					
96		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**REFE**
2						**CPT Code 69714**		**CPT Code 69714**		**CPT Co**
3		***RUC Collaboration Website***				Implantation, osseointegrated implant, temporal bone; with percutaneous attachment to		Implantation, osseointegrated implant, skull;, with percutaneous attachment to external speech processor		Implan osseoin implant, bone percut attach
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 18 Specialty: AAO-HNS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ 225.41**	**$ -**	**$ 138.38**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**183.0**	**0.0**	**204.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**6.0**	**0.0**	**36.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ 150.10**	**$ -**	**$ 55.81**	**$ -**
102	SA043	pack, cleaning, surgical instruments	10.7922	pack					3	
103	SA048	pack, minimum multi-specialty visit	4.0507	pack					3	
104	SA053	pack, post-op incision care (suture & staple)	5.63	pack			1		**0**	
105	SA054	pack, post-op incision care (suture)	4.6918	pack					**1**	
106	SB012	drape, sterile, for Mayo stand	1.2245	item			4			
107	SB024	gloves, sterile	0.8925	pair			1			
108	SB026	gown, patient	0.5757	item			4			
109	SB027	gown, staff, impervious	1.186	item			8			
110	SB034	mask, surgical, with face shield	3.4	item			8			
111	SB044	underpad 2ft x 3ft (Chux)	0.2975	item			4			
112	SD009	canister, suction	4.2095	item			4		1	
113	SD132	tubing, suction, non-latex (6ft uou)	0.9212	item			8		2	
114	SG006	adhesive remover, pad (acetone)	0.035	item			1			
115	SG016	bandage, Kerlix, sterile 4.5in	0.863	item			1			
116	SG020	bandage, Kling, sterile 4in	0.4975	item			1			
117	SG031	cottonoid	0.7933	item			4			
118	SG042	dressing, ear (Glasscock)	13.11	item			1			
119	SG055	gauze, sterile 4in x 4in	0.1823	item			14		2	
120	SG079	tape, surgical paper 1in (Micropore)	0.008	inch			48			
121	SG081	applicator, cotton-tipped, sterile, 6in	0.0562	item			16		1	
122	SG082	cotton balls, sterile	0.0279	item			4			
123	SH024	Cipro HC otic soln	10.23	ml			4			
124	SJ007	bacitracin oint (0.9gm uou)	0.1202	item			20		1	
125	SJ010	basin, emesis	0.2415	item			4			
126	SJ028	hydrogen peroxide	0.0307	ml			40			
127	SJ046	silver nitrate applicator	0.16	item			20			
128	SJ060	tincture of benzoin, swab	0.3275	item			1			
129	SM001	atomizer tip shield (RhinoGuard)	0.905	item			4			
130										
131		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
133	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
134		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ 7.60**	**$ -**	**$ 7.09**	**$ -**
135	EQ234	suction and pressure cabinet, ENT (SMR)	4032.9248	Office Visits	0.010702279		117		108.0	
136	EQ183	microscope, operating	7047.5	Office Visits	0.027923578		117		108.0	
137	EQ170	light, fiberoptic headlight w-source	3525.9372	Office Visits	0.013970455		117		108.0	
138	EF008	chair with headrest, exam, reclining	5565.6015	Office Visits	0.01238009		117		108.0	
139	EQ137	instrument pack, basic ($500-$1499)	500	Instrument Packs	0.002323783				30.0	
146										
147		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	L	M	N	O	P	Q	R	S	T
1	**RUC Practice Expense Spreadsheet**		**RENCE**	**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**REFERENCE**	
2			**de 69714**	**CPT Code 69716**		**CPT Code 69717**		**CPT Code 69717**		**CPT Code 69717**	
3		***RUC Collaboration Website***	tation,	Implantation,		Replacement (including		Revision/replacement		Replacement	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**	tegrated temporal ; with aneous nent to	osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		removal of existing device), osseointegrated implant, temporal bone; with percutaneous		(including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor		(including removal of existing device), osseointegrated implant, temporal bone; with	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 225.41**	**$ -**	**$ 104.16**	**$ -**	**$ 219.36**	**$ -**	**$ 138.38**	**$ -**	**$ 225.41**
8		**TOTAL CLINICAL STAFF TIME**	**183.0**	**0.0**	**158.0**	**0.0**	**183.0**	**0.0**	**204.0**	**0.0**	**183.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**36.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**117.0**	**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 67.71**	**$ -**	**$ 58.46**	**$ -**	**$ 67.71**	**$ -**	**$ 75.48**	**$ -**	**$ 67.71**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms	5		5		5		5		5
16	CA002	Coordinate pre-surgery services (including test results)	20		20		20		20		20
17	CA003	Schedule space and equipment in facility	8		8		8		8		8
18	CA004	Provide pre-service education/obtain consent	20		20		20		20		20
19	CA005	Complete pre-procedure phone calls and prescription	7		7		7		7		7
20	CA006	Confirm availability of prior images/studies									
21	CA007	Review patient clinical extant information and questionnaire									
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)									
23											
26		*Other activity: please include short clinical description here and type new in column A*									
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available									
34	CA010	Obtain vital signs									
35	CA011	Provide education/obtain consent									
36	CA012	Review requisition, assess for special needs									
37	CA013	Prepare room, equipment and supplies									
38	CA014	Confirm order, protocol exam									
39	CA015	Setup scope (nonfacility setting only)									
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient									
41	CA017	Sedate/apply anesthesia									
42											
45		*Other activity: please include short clinical description here and type new in column A*									
48		**Intra-service (of service period)**									
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)									
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)									
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)									
52	CA021	Perform procedure/service---NOT directly related to physician work time									
55											
56		*Other activity: please include short clinical description here and type new in column A*									
59		**Post-Service (of service period)**									
60	CA022	Monitor patient following procedure/service, multitasking 1:4									
61	CA023	Monitor patient following procedure/service, no multitasking									
62	CA024	Clean room/equipment by clinical staff									
63	CA025	Clean scope									
64	CA026	Clean surgical instrument package			20				30		
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions									
66	CA028	Review/read post-procedure x-ray, lab and pathology reports									
67	CA029	Check dressings, catheters, wounds									
68	CA030	Technologist QCs images in PACS, checking for all images, reformats, and dose page									
69	CA031	Review examination with interpreting MD/DO									
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue									
71	CA033	Perform regulatory mandated quality assurance activity (service period)									
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, ESRD flow sheet)									
73	CA035	Review home care instructions, coordinate visits/prescriptions									
74	CA036	Discharge day management	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**
75											
78		*Other activity: please include short clinical description here and type new in column A*									
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037	Conduct patient communications									
85	CA038	Coordinate post-procedure services									
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes									
88		99212 27 minutes	3				3				3
89		99213 36 minutes	1		2		1		3		1
90		99214 53 minutes									
91		99215 63 minutes									
92	CA039	Post-operative visits (total time)	**117.0**	**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**
93											
96		*Other activity: please include short clinical description here and type new in column A*									
99		**End: with last office visit before end of global period**									

	A	B	L	M	N	O	P	Q	R	S	T
1	**RUC Practice Expense Spreadsheet**		**RENCE**	**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**REFERENCE**	
2			**de 69714**	**CPT Code 69716**		**CPT Code 69717**		**CPT Code 69717**		**CPT Code 69717**	
3		***RUC Collaboration Website***	tation, tegrated temporal ; with aneous nent to	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with percutaneous		Revision/replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**									
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 225.41**	**$ -**	**$ 104.16**	**$ -**	**$ 219.36**	**$ -**	**$ 138.38**	**$ -**	**$ 225.41**
8		**TOTAL CLINICAL STAFF TIME**	**183.0**	**0.0**	**158.0**	**0.0**	**183.0**	**0.0**	**204.0**	**0.0**	**183.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**6.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**36.0**	**0.0**	**6.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**117.0**	**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**108.0**	**0.0**	**117.0**
100	**Supply Code**	**MEDICAL SUPPLIES**									
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 150.10**	**$ -**	**$ 40.97**	**$ -**	**$ 144.04**	**$ -**	**$ 55.81**	**$ -**	**$ 150.10**
102	SA043	pack, cleaning, surgical instruments			2				3		
103	SA048	pack, minimum multi-specialty visit			2				3		
104	SA053	pack, post-op incision care (suture & staple)	1		**0**		1		**0**		1
105	SA054	pack, post-op incision care (suture)			**1**				**1**		
106	SB012	drape, sterile, for Mayo stand	4				4				4
107	SB024	gloves, sterile	1				1				1
108	SB026	gown, patient	4				4				4
109	SB027	gown, staff, impervious	8				8				8
110	SB034	mask, surgical, with face shield	8				4				8
111	SB044	underpad 2ft x 3ft (Chux)	4				4				4
112	SD009	canister, suction	4		1		4		1		4
113	SD132	tubing, suction, non-latex (6ft uou)	8		2		8		2		8
114	SG006	adhesive remover, pad (acetone)	1				1				1
115	SG016	bandage, Kerlix, sterile 4.5in	1				1				1
116	SG020	bandage, Kling, sterile 4in	1				1				1
117	SG031	cottonoid	4				4				4
118	SG042	dressing, ear (Glasscock)	1				1				1
119	SG055	gauze, sterile 4in x 4in	14		2		14		2		14
120	SG079	tape, surgical paper 1in (Micropore)	48				48				48
121	SG081	applicator, cotton-tipped, sterile, 6in	16		1		16		1		16
122	SG082	cotton balls, sterile	4				4				4
123	SH024	Cipro HC otic soln	4				4				4
124	SJ007	bacitracin oint (0.9gm uou)	20		1		4		1		20
125	SJ010	basin, emesis	4				20				4
126	SJ028	hydrogen peroxide	40				4				40
127	SJ046	silver nitrate applicator	20				40				20
128	SJ060	tincture of benzoin, swab	1				20				1
129	SM001	atomizer tip shield (RhinoGuard)	4				1				4
130							4				
131		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
133	**Equipment Code**	**EQUIPMENT**									
134		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 7.60**	**$ -**	**$ 4.72**	**$ -**	**$ 7.60**	**$ -**	**$ 7.09**	**$ -**	**$ 7.60**
135	EQ234	suction and pressure cabinet, ENT (SMR)	117		72.0		117		108.0		117
136	EQ183	microscope, operating	117		72.0		117		108.0		117
137	EQ170	light, fiberoptic headlight w-source	117		72.0		117		108.0		117
138	EF008	chair with headrest, exam, reclining	117		72.0		117		108.0		117
139	EQ137	instrument pack, basic ($500-$1499)			20.0				30.0		
146											
147		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	U	V	W	X	Y	Z	AA	AB	AC
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**REFERENCE**		**RECOMMENDED**		**REFERENCE**		**RECOMM**
2			**CPT Code 69719**		**CPT Code 69717**		**CPT Code 69726**		**CPT Code 69717**		**CPT Co**
3		***RUC Collaboration Website***	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Rem osseointegra skull; with transcu attachmen speech p
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**									
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 104.16**	**$ -**	**$ 225.41**	**$ -**	**$ 100.24**	**$ -**	**$ 225.41**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**158.0**	**0.0**	**183.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ 58.46**	**$ -**	**$ 67.71**	**$ -**	**$ 55.13**	**$ -**	**$ 67.71**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms		5		5		5		5	
16	CA002	Coordinate pre-surgery services (including test results)		20		20		20		20	
17	CA003	Schedule space and equipment in facility		8		8		8		8	
18	CA004	Provide pre-service education/obtain consent		20		20		20		20	
19	CA005	Complete pre-procedure phone calls and prescription		7		7		7		7	
20	CA006	Confirm availability of prior images/studies									
21	CA007	Review patient clinical extant information and questionnaire									
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)									
23											
26		*Other activity: please include short clinical description here and type new in column A*									
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available									
34	CA010	Obtain vital signs									
35	CA011	Provide education/obtain consent									
36	CA012	Review requisition, assess for special needs									
37	CA013	Prepare room, equipment and supplies									
38	CA014	Confirm order, protocol exam									
39	CA015	Setup scope (nonfacility setting only)									
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient									
41	CA017	Sedate/apply anesthesia									
42											
45		*Other activity: please include short clinical description here and type new in column A*									
48		**Intra-service (of service period)**									
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)									
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)									
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)									
52	CA021	Perform procedure/service---NOT directly related to physician work time									
55											
56		*Other activity: please include short clinical description here and type new in column A*									
59		**Post-Service (of service period)**									
60	CA022	Monitor patient following procedure/service, multitasking 1:4									
61	CA023	Monitor patient following procedure/service, no multitasking									
62	CA024	Clean room/equipment by clinical staff									
63	CA025	Clean scope									
64	CA026	Clean surgical instrument package		20				20			
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions									
66	CA028	Review/read post-procedure x-ray, lab and pathology reports									
67	CA029	Check dressings, catheters, wounds									
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page									
69	CA031	Review examination with interpreting MD/DO									
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to complete images into work queue									
71	CA033	Perform regulatory mandated quality assurance activity (service period)									
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, ESC flowsheet)									
73	CA035	Review home care instructions, coordinate visits/prescriptions									
74	CA036	Discharge day management	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**	**6**	**n/a**
75											
78		*Other activity: please include short clinical description here and type new in column A*									
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037	Conduct patient communications									
85	CA038	Coordinate post-procedure services									
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes									
88		99212 27 minutes				3		1		3	
89		99213 36 minutes		2		1		1		1	
90		99214 53 minutes									
91		99215 63 minutes									
92	CA039	Post-operative visits (total time)	**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**
93											
96		*Other activity: please include short clinical description here and type new in column A*									
99		**End: with last office visit before end of global period**									

	A	B	U	V	W	X	Y	Z	AA	AB	AC
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**REFERENCE**		**RECOMMENDED**		**REFERENCE**		**RECOMM**
2			**CPT Code 69719**		**CPT Code 69717**		**CPT Code 69726**		**CPT Code 69717**		**CPT Co**
3		***RUC Collaboration Website***	Revision/replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Removal, osseointegrated implant, skull; with percutaneous attachment to external speech processor		Replacement (including removal of existing device), osseointegrated implant, temporal bone; with		Rem osseointegra skull; with transcu attachmen speech p
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**									
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 104.16**	**$ -**	**$ 225.41**	**$ -**	**$ 100.24**	**$ -**	**$ 225.41**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**158.0**	**0.0**	**183.0**	**0.0**	**149.0**	**0.0**	**183.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**	**26.0**	**0.0**	**6.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**72.0**	**0.0**	**117.0**	**0.0**	**63.0**	**0.0**	**117.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**									
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ 40.97**	**$ -**	**$ 150.10**	**$ -**	**$ 40.97**	**$ -**	**$ 150.10**	**$ -**
102	SA043	pack, cleaning, surgical instruments		2				2			
103	SA048	pack, minimum multi-specialty visit		2				2			
104	SA053	pack, post-op incision care (suture & staple)		**0**		1		**0**		1	
105	SA054	pack, post-op incision care (suture)		**1**				**1**			
106	SB012	drape, sterile, for Mayo stand				4				4	
107	SB024	gloves, sterile				1				1	
108	SB026	gown, patient				4				4	
109	SB027	gown, staff, impervious				8				8	
110	SB034	mask, surgical, with face shield				8				8	
111	SB044	underpad 2ft x 3ft (Chux)				4				4	
112	SD009	canister, suction		1		4		1		4	
113	SD132	tubing, suction, non-latex (6ft uou)		2		8		2		8	
114	SG006	adhesive remover, pad (acetone)				1				1	
115	SG016	bandage, Kerlix, sterile 4.5in				1				1	
116	SG020	bandage, Kling, sterile 4in				1				1	
117	SG031	cottonoid				4				4	
118	SG042	dressing, ear (Glasscock)				1				1	
119	SG055	gauze, sterile 4in x 4in		2		14		2		14	
120	SG079	tape, surgical paper 1in (Micropore)				48				48	
121	SG081	applicator, cotton-tipped, sterile, 6in		1		16		1		16	
122	SG082	cotton balls, sterile				4				4	
123	SH024	Cipro HC otic soln				4				4	
124	SJ007	bacitracin oint (0.9gm uou)		1		20		1		20	
125	SJ010	basin, emesis				4				4	
126	SJ028	hydrogen peroxide				40				40	
127	SJ046	silver nitrate applicator				20				20	
128	SJ060	tincture of benzoin, swab				1				1	
129	SM001	atomizer tip shield (RhinoGuard)				4				4	
130											
131		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
133	**Equipment Code**	**EQUIPMENT**									
134		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ 4.72**	**$ -**	**$ 7.60**	**$ -**	**$ 4.14**	**$ -**	**$ 7.60**	**$ -**
135	EQ234	suction and pressure cabinet, ENT (SMR)		72.0		117		63.0		117	
136	EQ183	microscope, operating		72.0		117		63.0		117	
137	EQ170	light, fiberoptic headlight w-source		72.0		117		63.0		117	
138	EF008	chair with headrest, exam, reclining		72.0		117		63.0		117	
139	EQ137	instrument pack, basic ($500-$1499)		20.0				20.0			
146											
147		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	AD
1	**RUC Practice Expense Spreadsheet**		**MENDED**
2			**de 69727**
3		***RUC Collaboration Website***	oval,
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**	ted implant, magnetic aneous to external rocessor
5		**LOCATION**	**Facility**
6		**GLOBAL PERIOD**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 100.24**
8		**TOTAL CLINICAL STAFF TIME**	**149.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**26.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**63.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 55.13**
13		**PRE-SERVICE PERIOD**	
14		**Start: Following visit when decision for surgery/procedure made**	
15	CA001	Complete pre-service diagnostic and referral forms	5
16	CA002	Coordinate pre-surgery services (including test results)	20
17	CA003	Schedule space and equipment in facility	8
18	CA004	Provide pre-service education/obtain consent	20
19	CA005	Complete pre-procedure phone calls and prescription	7
20	CA006	Confirm availability of prior images/studies	
21	CA007	Review patient clinical extant information and questionnaire	
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	
23			
26		*Other activity: please include short clinical description here and type new in column A*	
29		**End: When patient enters office/facility for surgery/procedure**	
30		**SERVICE PERIOD**	
31		**Start: When patient enters office/facility for surgery/procedure:**	
32		**Pre-Service (of service period)**	
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	
34	CA010	Obtain vital signs	
35	CA011	Provide education/obtain consent	
36	CA012	Review requisition, assess for special needs	
37	CA013	Prepare room, equipment and supplies	
38	CA014	Confirm order, protocol exam	
39	CA015	Setup scope (nonfacility setting only)	
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	
41	CA017	Sedate/apply anesthesia	
42			
45		*Other activity: please include short clinical description here and type new in column A*	
48		**Intra-service (of service period)**	
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (50%)	
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)	
52	CA021	Perform procedure/service---NOT directly related to physician work time	
55			
56		*Other activity: please include short clinical description here and type new in column A*	
59		**Post-Service (of service period)**	
60	CA022	Monitor patient following procedure/service, multitasking 1:4	
61	CA023	Monitor patient following procedure/service, no multitasking	
62	CA024	Clean room/equipment by clinical staff	
63	CA025	Clean scope	
64	CA026	Clean surgical instrument package	20
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	
67	CA029	Check dressings, catheters, wounds	
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	
69	CA031	Review examination with interpreting MD/DO	
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to complete images into work queue	
71	CA033	Perform regulatory mandated quality assurance activity (service period)	
72	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, ESC flow sheet)	
73	CA035	Review home care instructions, coordinate visits/prescriptions	
74	CA036	Discharge day management	**6**
75			
78		*Other activity: please include short clinical description here and type new in column A*	
81		**End: Patient leaves office/facility**	
82		**POST-SERVICE PERIOD**	
83		**Start: Patient leaves office/facility**	
84	CA037	Conduct patient communications	
85	CA038	Coordinate post-procedure services	
86		***Office visits: List Number and Level of Office Visits***	**# visits**
87		99211 16 minutes	
88		99212 27 minutes	1
89		99213 36 minutes	1
90		99214 53 minutes	
91		99215 63 minutes	
92	CA039	Post-operative visits (total time)	**63.0**
93			
96		*Other activity: please include short clinical description here and type new in column A*	
99		**End: with last office visit before end of global period**	

	A	B	AD
1	**RUC Practice Expense Spreadsheet**		**MENDED**
2			**de 69727**
3		***RUC Collaboration Website***	oval, ted implant, magnetic aneous to external rocessor
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 18** **Specialty: AAO-HNS**	
5		**LOCATION**	**Facility**
6		**GLOBAL PERIOD**	**090**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 100.24**
8		**TOTAL CLINICAL STAFF TIME**	**149.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**60.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**26.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**63.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 40.97**
102	SA043	pack, cleaning, surgical instruments	2
103	SA048	pack, minimum multi-specialty visit	2
104	SA053	pack, post-op incision care (suture & staple)	**0**
105	SA054	pack, post-op incision care (suture)	**1**
106	SB012	drape, sterile, for Mayo stand	
107	SB024	gloves, sterile	
108	SB026	gown, patient	
109	SB027	gown, staff, impervious	
110	SB034	mask, surgical, with face shield	
111	SB044	underpad 2ft x 3ft (Chux)	
112	SD009	canister, suction	1
113	SD132	tubing, suction, non-latex (6ft uou)	2
114	SG006	adhesive remover, pad (acetone)	
115	SG016	bandage, Kerlix, sterile 4.5in	
116	SG020	bandage, Kling, sterile 4in	
117	SG031	cottonoid	
118	SG042	dressing, ear (Glasscock)	
119	SG055	gauze, sterile 4in x 4in	2
120	SG079	tape, surgical paper 1in (Micropore)	
121	SG081	applicator, cotton-tipped, sterile, 6in	1
122	SG082	cotton balls, sterile	
123	SH024	Cipro HC otic soln	
124	SJ007	bacitracin oint (0.9gm uou)	1
125	SJ010	basin, emesis	
126	SJ028	hydrogen peroxide	
127	SJ046	silver nitrate applicator	
128	SJ060	tincture of benzoin, swab	
129	SM001	atomizer tip shield (RhinoGuard)	
130			
131		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*	
133	**Equipment Code**	**EQUIPMENT**	
134		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 4.14**
135	EQ234	suction and pressure cabinet, ENT (SMR)	63.0
136	EQ183	microscope, operating	63.0
137	EQ170	light, fiberoptic headlight w-source	63.0
138	EF008	chair with headrest, exam, reclining	63.0
139	EQ137	instrument pack, basic ($500-$1499)	20.0
146			
147		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Trabecular Bone Score (TBS) – Tab 19

In October 2020, the CPT Editorial Panel created four new CPT codes to describe trabecular bone score (TBS) analysis. CPT codes 77090 and 77091 involve only technical work. The specialty noted that TBS can be performed synchronously with a dual-energy X-ray absorptiometry (DXA) or if a patient had a prior DXA within a clinically relevant amount of time. In addition, TBS analysis for bone micro architecture can also be performed on a previous appropriately acquired CT scanogram or other appropriate imaging study, avoiding the need for the patient to undergo additional imaging. TBS can also be a stand-alone service with imaging acquired independently of a DXA scan or separate imaging scan; that is the reason the service was created as an XXX base code instead of an add-on service. TBS is an independent variable for assessing a patient's osteoporatic risk and fracture risk.

77089 ***Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual X-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk***
The RUC reviewed the survey results from 33 diagnostic radiologists and recommends the survey 25th percentile work RVU of 0.20 for CPT code 77089. The RUC recommends 2 minutes of pre-service time, 5 minutes of intra-service time and 2 minutes of post-service time. The specialty noted that the physician work performed by the radiologist is identical for services 77089 and 77092 and that the sole distinction between these two services is related to practice expense.

The specialty noted that for most of the physician time, the interpreting physician is assessing the images provided, assessing the areas of the target analysis and then reviewing that data in comparison to other clinical information. Both DXA and TBS involve an extensive clinical questionnaire because the data cannot be assessed in the absence of appropriate clinical history, medication review and the patient's prior pertinent studies. Both for DXA and TBS, if the patient has prior fractures in the areas of analysis that would be a feedback in which the interpreting physician would need to associate or analyze a different area within that bone, because it would be possible to get spurious or incorrect data.

To justify a value of 0.20, the RUC compared the survey code to 2nd key reference code 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work RVU= 0.20, intra-service time of 5 minutes, total time of 9 minutes) and noted that both services typically involve an identical amount of time and physician work for the radiologist performing the service. The RUC also compared the survey code to MPC code 74019 *Radiologic examination, abdomen; 2 views* (work RVU= 0.23, intra-service time of 4 minutes, total time of 6 minutes) and noted that the MPC code, with three minutes less of total time, is a slightly more intense service to perform. **The RUC recommends a work RVU of 0.20 for CPT code 77089.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

77092 ***Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified health care professional***
The RUC reviewed the survey results from 33 diagnostic radiologists and recommends the survey median work RVU of 0.20 for CPT code 77092. The RUC recommends 2 minutes of pre-service time, 5 minutes of intra-service time and 2 minutes of post-service time. The specialty noted that the physician work performed by the radiologist is identical for services 77089 and 77092 and that the sole distinction between these two services is related to practice expense.

The specialty noted that, for this service, the interpreting physician is assessing the images provided and then assessing the areas of the target analysis and then reviewing that data in comparison to other clinical information. Both DXA and TBS involve an extensive clinical questionnaire because the data cannot be assessed in the absence of appropriate clinical history, medication review and the patient's prior pertinent studies. For both DXA and TBS, if the patient has prior fractures in the areas of analysis that would be a feedback in which the interpreting physician would have to associate or analyze a different area within that bone, because it would be possible to get spurious or incorrect data.

To justify a value of 0.20, the RUC compared the survey code to 2nd key reference code 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)* (work RVU= 0.20, intra-service time of 5 minutes, total time of 9 minutes) and noted that both services typically involve an identical amount of time and physician work for the radiologist performing the service. The RUC also compared the survey code to MPC code 74019 *Radiologic examination, abdomen; 2 views* (work RVU= 0.23, intra-service time of 4 minutes, total time of 6 minutes) and noted that the MPC code, with three minutes less of total time, is a slightly more intense service to perform. **The RUC recommends a work RVU of 0.20 for CPT code 77092.**

Practice Expense
The Practice Expense Subcommittee reviewed the proposed direct practice expense inputs and agreed they were appropriate, as proposed by the specialty. The specialty explained that CPT code 77089 describes the complete TBS service when the TBS software is installed on the imaging equipment, including physician review and interpretation of the TBS report. CPT code 77090 is used to report when data is extracted from the imaging equipment and sent elsewhere for TBS analysis. CPT code 77091 is used when only TBS is performed, and CPT code 77092 captures the physician review and interpretation of TBS. CPT codes 77090 and 77091 are technical work only. The Subcommittee agreed that it would be warranted to include a per encounter software licensing fee for the TBS software for CPT codes 77089 and 77091. The software is currently sold "per click" or per scan. As this is a per-patient, single-use item, it is appropriately included as a supply item and not an equipment item, which is typically accounted for by minutes used. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology/New Service
The RUC recommends that CPT codes 77089-77092 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Radiology **Bone/Joint Studies**				
●77089	V1	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual X-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk (Do not report 77089 in conjunction with 77090, 77091, 77092)	XXX	0.20
●77090	V2	technical preparation and transmission of data for analysis to be performed elsewhere	XXX	0.00 (PE Only)
●77091	V3	technical calculation only	XXX	0.00 (PE Only)
●77092	V4	interpretation and report on fracture risk only, by other qualified health care professional (Do not report 77090, 77091, 77092 in conjunction with 77089)	XXX	0.20

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77089 Tracking Number V1 Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.20**

CPT Descriptor: Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 69-year-old female who had a previous bone density study, which demonstrated osteopenia.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the order and reason for the examination and any pertinent clinical history, including the patient's clinical information sheet. Review any prior TBS or DXA studies or other relevant studies to determine appropriate site.

Description of Intra-Service Work: Verify that the previously acquired images (e.g. DXA, etc.) are appropriate for TBS analysis, including quality control and no exclusion of anatomy or artifact. Open the images in the TBS software, separate from PACS, and verify that images have transferred appropriately. Identify the appropriate population reference control. Review images to determine region to be included in calculations. Interpret the TBS data and compare to established norms, including risk analysis to determine if fracture risk (FRAX) analysis, reported separately, is indicated. Compare the results to previous studies. Compare the reported values to population standards. Transfer TBS images to PACS. Dictate report.

Description of Post-Service Work: Review, edit, and sign the final report. Communicate results to the referring provider or the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021		
Presenter(s):	Kurt Schoppe, MD; Lauren Golding, MD; Andy Moriarity, MD		
Specialty Society(ies):	American College of Radiology		
CPT Code:	77089		
Sample Size:	3374	**Resp N:**	33
Description of Sample:	The ACR surveyed a random sample of 1,596 of its membership who indicated that they perform procedures in the modalities of gynecologic radiation oncology, mammography, women's imaging, musculoskeletal, and interventional radiology. The ACR also surveyed a random sample of 1,596 of all of its membership. Additionally, the ACR surveyed 182 individuals from the vendor MediMaps. This is a total of 3,374 individuals who were surveyed.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**50.00**	200.00	1500.00
Survey RVW:	0.08	0.20	**0.30**	0.36	4.00
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	3.00	**5.00**	6.00	10.00

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	77089	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**2.00**	**0.00**	**2.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77085	XXX	0.30	**RUC Time**

CPT Descriptor Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77081	XXX	0.20	**RUC Time**

CPT Descriptor Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92567	XXX	0.20	**RUC Time**	922,916

CPT Descriptor 1 Tympanometry (impedance testing)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74019	XXX	0.23	**RUC Time**	429,437

CPT Descriptor 2 Radiologic examination, abdomen; 2 views

Other Reference CPT Code	Global	Work RVU	Time Source
72081	XXX	0.26	**RUC Time**

CPT Descriptor Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 39.3 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 36.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 77089	Top Key Reference CPT Code: 77085	2nd Key Reference CPT Code: **77081**
Median Pre-Service Time	2.00	3.00	2.00
Median Intra-Service Time	5.00	8.00	5.00
Median Immediate Post-service Time	2.00	3.00	2.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**9.00**	**14.00**	**9.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	77%	15%	8%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	77%	23%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	69%	31%

Physical effort required	0%	77%	23%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	23%	62%	15%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	8%	33%	33%	25%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	58%	25%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	25%	50%	25%
Physical effort required	33%	58%	8%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	42%	50%	8%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

At the October 2020 CPT Editorial Panel meeting, four new codes (CPT codes 77089, 77090, 77091, and 77092) were created for Trabecular Bone Score (TBS) analysis. The code descriptions can be seen in the table

below. As CPT codes 77090 and 77091 involve only technical work, the American College of Radiology (ACR) surveyed CPT codes 77089 and 77092 for the January 2021 RUC meeting and convened an expert panel of physicians familiar with this service to review the survey data.

CPT Code	Descriptor
77089	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk *(Do not report 77089 in conjunction with 77090, 77091, 77092)*
77090	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere *(Do not report 77090, 77091, 77092 in conjunction with 77089)*
77091	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only *(Do not report 77090, 77091, 77092 in conjunction with 77089)*
77092	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional *(Do not report 77090, 77091, 77092 in conjunction with 77089)*

TBS is a measurement of the structural condition of the bone microarchitecture. It is strongly correlated with 3D bone microarchitecture parameters such as the structure model index, the number of trabeculae and their connectivity and negatively with the space between trabeculae. A high TBS value means that microarchitecture bone is dense, well connected with little spaces between trabeculae and fairly homogenously distributed. Conversely, a low TBS value means that the microarchitecture of bone is incomplete and poorly connected with wide spaces between trabeculae and heterogeneously distributed. TBS predicts the risk of major osteoporotic fracture independently of bone mineral density (BMD) and clinical risk factors. The TBS score helps physicians better classify patients for risk of fracture and subsequently help guide decisions about the course of care for the patient.

The TBS software can reside directly on a DXA or X-ray machine or the necessary data can be exported from the DXA machine to an imaging workstation, enabling the TBS analysis to be performed separately from image acquisition, either on site or at another location. Additionally, TBS can be performed retrospectively provided that appropriate gray-scale data exists for export and analysis.

For the TBS code family, CPT code 77089 describes the complete TBS service when the TBS software is installed on the imaging equipment, including physician review and interpretation of the TBS report. CPT code 77090 is used to report when data is extracted from the imaging equipment and sent elsewhere for TBS analysis. CPT code 77091 is used when only TBS is performed, and CPT code 77092 captures the physician review and interpretation of TBS. 77090 and 77091 are technical work only. It is important to understand that, from the perspective of physician work, 77089 and 77092 are the same.

Below is a table of the DXA codes, which would most often be performed with the TBS services as a reference.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	RUC Meeting Date
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	0.20	2	5	2	9	0.022	October 2013

77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	0.20	2	5	2	9	0.022	January 2018
77089	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk**	**0.20**	**2**	**5**	**2**	**9**	**0.022**	**January 2021**
77092	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional**	**0.20**	**2**	**5**	**2**	**9**	**0.022**	**January 2021**
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	0.30	3	8	3	14	0.021	October 2013
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	0.17	2	5	2	9	0.016	October 2013

Survey Process

The ACR surveyed a random sample of 1,596 of its membership who indicated that they perform procedures in the modalities of gynecologic radiation oncology, mammography, women's imaging, musculoskeletal, and interventional radiology. The ACR also surveyed a random sample of 1,596 of all of its membership. Additionally, the ACR surveyed 182 individuals from the vendor MediMaps. This is a total of 3,374 individuals who were surveyed.

Work RVU and Time Recommendations

The expert panel recommends the survey 25th percentile value at 0.20 work RVU and survey median times of 2 minutes pre-service, 5 minutes intra-service, and 2 minutes post-service.

Key Reference Services

Approximately two thirds of the survey respondents chose one of the top two key reference services, both of which are DXA codes, which have similar work and patient populations compared to the surveyed code, 77089. Our recommended work RVU of 0.20 compares favorably to the most commonly chosen key reference service, CPT code 77085 *(Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment),* as this exam is performed on a similar patient population and requires similar physician work.

The second key reference service code, 77081 *(Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)),* supports the recommendation by providing a relative upper bound on work compared to the times indicated by the surveyed physicians.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	0.20	2	5	2	9	0.022
77089	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk**	**0.20**	**2**	**5**	**2**	**9**	**0.022**
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	0.30	3	8	3	14	0.021

MPC Codes

Our recommendation for CPT code 77089 compares favorably to the following MPC codes depicted in the table below. Specifically, the value recommendation has slightly higher intra-service and total times, but the same or lower work RVU compared to these MPC codes.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT
92567	Tympanometry (impedance testing)	0.20	1	4	1	6	0.039
77089	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation**	**0.20**	**2**	**5**	**2**	**9**	**0.022**

	and report on fracture risk						
74019	Radiologic examination, abdomen; 2 views	0.23	1	4	1	6	0.046
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	0.26	1	5	1	7	0.043

Summary:

In summary, our expert panel recommends the 25th survey percentile at 0.20 work RVU with survey median times of 2 minutes pre-service, 5 minutes intra-service, and 2 minutes post-service. The recommended value compares favorably with the key reference services, 77085 and 77081, and maintains relativity within the RBRVS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This is a new code.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 380000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 77089 is estimated to be provided 380,000 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 91200 Percentage 24.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 380,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 77089 is estimated to be provided 380,000 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 91200 Percentage 24.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Standard imaging

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 77081

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77092 Tracking Number V4 Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.20**

CPT Descriptor: Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female with antecedent of breast cancer treated with anti-aromatase.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the order and reason for the examination and any pertinent clinical history, including the patient's clinical information sheet. Review any prior TBS or DXA studies or other relevant studies to determine appropriate site.

Description of Intra-Service Work: Verify that the previously acquired images (e.g. DXA, etc.) are appropriate for TBS analysis, including quality control and no exclusion of anatomy or artifact. Open the images in the TBS software, separate from PACS, and verify that images have transferred appropriately. Identify the appropriate population reference control. Review images to determine region to be included in calculations. Interpret the TBS data and compare to established norms, including risk analysis to determine if fracture risk (FRAX) analysis, reported separately, is indicated. Compare the results to previous studies. Compare the reported values to population standards. Transfer TBS images to PACS. Dictate report.

Description of Post-Service Work: Review, edit, and sign the final report. Communicate results to the referring provider or the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Kurt Schoppe, MD; Lauren Golding, MD; Andy Moriarity, MD					
Specialty Society(ies):	American College of Radiology					
CPT Code:	77092					
Sample Size:	3374	**Resp N:**	33			
Description of Sample:	The ACR surveyed a random sample of 1,596 of its membership who indicated that they perform procedures in the modalities of gynecologic radiation oncology, mammography, women's imaging, musculoskeletal, and interventional radiology. The ACR also surveyed a random sample of 1,596 of all of its membership. Additionally, the ACR surveyed 182 individuals from the vendor MediMaps. This is a total of 3,374 individuals who were surveyed.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**10.00**	73.00	960.00
Survey RVW:	0.08	0.20	**0.30**	0.32	4.00
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	3.00	**5.00**	6.00	10.00

Immediate Post Service-Time:	**2.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	77092	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**2.00**	**0.00**	**2.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77085	XXX	0.30	**RUC Time**

CPT Descriptor Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77081	XXX	0.20	**RUC Time**

CPT Descriptor Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92567	XXX	0.20	**RUC Time**	922,916

CPT Descriptor 1 Tympanometry (impedance testing)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74019	XXX	0.23	**RUC Time**	429,437

CPT Descriptor 2 Radiologic examination, abdomen; 2 views

Other Reference CPT Code	Global	Work RVU	Time Source
72081	XXX	0.26	**RUC Time**

CPT Descriptor Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 39.3 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 77092	Top Key Reference CPT Code: 77085	2nd Key Reference CPT Code: **77081**
Median Pre-Service Time	2.00	3.00	2.00
Median Intra-Service Time	5.00	8.00	5.00
Median Immediate Post-service Time	2.00	3.00	2.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**9.00**	**14.00**	**9.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	69%	23%	8%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	69%	31%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	62%	38%

Physical effort required	0%	77%	23%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	23%	62%	15%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	9%	27%	55%	9%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	18%	73%	9%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	27%	55%	18%
Physical effort required	36%	64%	0%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	36%	64%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

At the October 2020 CPT Editorial Panel meeting, four new codes (CPT codes 77089, 77090, 77091, and 77092) were created to describe Trabecular Bone Score (TBS) analysis. The code descriptions can be seen in

the table below. As CPT codes 77090 and 77091 involve only technical work, the American College of Radiology (ACR) surveyed CPT codes 77089 and 77092 for the January 2021 RUC meeting and convened an expert panel of physicians familiar with this service to review the survey data.

CPT Code	Descriptor
77089	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk *(Do not report 77089 in conjunction with 77090, 77091, 77092)*
77090	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere *(Do not report 77090, 77091, 77092 in conjunction with 77089)*
77091	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only *(Do not report 77090, 77091, 77092 in conjunction with 77089)*
77092	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional *(Do not report 77090, 77091, 77092 in conjunction with 77089)*

TBS is a measurement of the structural condition of the bone microarchitecture. It is strongly correlated with 3D bone microarchitecture parameters such as the structure model index, the number of trabeculae and their connectivity and negatively with the space between trabeculae. A high TBS value means that microarchitecture bone is dense, well connected with little spaces between trabeculae and fairly homogenously distributed. Conversely, a low TBS value means that the microarchitecture of bone is incomplete and poorly connected with wide spaces between trabeculae and heterogeneously distributed. TBS predicts the risk of major osteoporotic fracture independently of bone mineral density (BMD) and clinical risk factors. The TBS score helps physicians better classify patients for risk of fracture and subsequently help guide decisions about the course of care for the patient.

The TBS software can reside directly on a DXA or X-ray machine or the necessary data can be exported from the DXA machine to an imaging workstation, enabling the TBS analysis to be performed separately from image acquisition, either on site or at another location. Additionally, TBS can be performed retrospectively provided that appropriate gray-scale data exists for export and analysis.

For the TBS code family, CPT code 77089 describes the complete TBS service when the TBS software is installed on the imaging equipment, including physician review and interpretation of the TBS report. CPT code 77090 is used to report when data is extracted from the imaging equipment and sent elsewhere for TBS analysis. CPT code 77091 is used when only TBS is performed, and CPT code 77092 captures the physician review and interpretation of TBS. 77090 and 77091 are technical work only. It is important to understand that, from the perspective of physician work, 77089 and 77092 are the same.

Below is a table of the DXA codes, which would most often be performed with the TBS services as a reference.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	RUC Meeting Date
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	0.20	2	5	2	9	0.022	October 2013

77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	0.20	2	5	2	9	0.022	January 2018
77089	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk**	**0.20**	**2**	**5**	**2**	**9**	**0.022**	**January 2021**
77092	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional**	**0.20**	**2**	**5**	**2**	**9**	**0.022**	**January 2021**
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	0.30	3	8	3	14	0.021	October 2013
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	0.17	2	5	2	9	0.016	October 2013

Survey Process

The ACR surveyed a random sample of 1,596 of its membership who indicated that they perform procedures in the modalities of gynecologic radiation oncology, mammography, women's imaging, musculoskeletal, and interventional radiology. The ACR also surveyed a random sample of 1,596 of all of its membership. Additionally, the ACR surveyed 182 individuals from the vendor MediMaps. This is a total of 3,374 individuals who were surveyed.

Work RVU and Time Recommendations

The expert panel recommends the 25th survey percentile value at 0.20 work RVU with survey median times of 2 minutes pre-service, 5 minutes intra-service, and 2 minutes post-service.

Key Reference Services

Approximately two thirds of the survey respondents chose one of the top two key reference services, both of which are DXA codes, which have similar work and patient populations compared to the surveyed code, 77092. Our recommended work RVU of 0.20 compares favorably to the most commonly chosen key reference service, CPT code 77085 *(Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment),* as this exam is performed on a similar patient population and requires similar physician work.

The second key reference service code, 77081 *(Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)),* supports the recommendation by providing a relative upper bound on work compared to the times indicated by the surveyed physicians.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT
77081	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	0.20	2	5	2	9	0.022
77092	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional**	**0.20**	**2**	**5**	**2**	**9**	**0.022**
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	0.30	3	8	3	14	0.021

MPC Codes

Our recommendation for CPT code 77092 compares favorably to the MPC codes as depicted in the table below. Specifically, the value recommendation has slightly higher intra-service and total times, but the same or lower work RVU compared to these MPC codes.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT
92567	Tympanometry (impedance testing)	0.20	1	4	1	6	0.039
77092	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare**	**0.20**	**2**	**5**	**2**	**9**	**0.022**

	professional						
74019	Radiologic examination, abdomen; 2 views	0.23	1	4	1	6	0.046
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	0.26	1	5	1	7	0.043

Summary:

In summary, our expert panel recommends the 25th survey percentile value at 0.20 work RVU with survey median times of 2 minutes pre-service, 5 minutes intra-service, and 2 minutes post-service. The recommended value compares favorably with the key reference services, 77085 and 77081, and maintains relativity within the RBRVS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This is a new code.

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 20000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 77092 is estimated to be provided 20,000 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 4800 Percentage 24.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 77092 is estimated to be provided 20,000 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 4800 Percentage 24.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Standard imaging

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 77081

SS Rec Summary

ISSUE: Trabecular Bone Score (TBS)
TAB: 19

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	77085	XXX	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including	13	0.021	0.021			0.30			14	3					8			3					
2nd REF	77081	XXX	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius,	12	0.022	0.022			0.20			9	2					5			2					
CURRENT			N/A																							
SVY	77089	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk	33	0.042	0.033	0.08	0.20	0.30	0.36	4.00	9	2			1	3	5	6	10	2	0	2	50	200	1500
SVY - Random	77089	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or	7	0.052	0.039	0.20	0.30	0.35	0.40	4.00	9	2			3	3	5	6	8	2	0	0	1	100	1500
SVY - Subset	77089	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or	16	0.047	0.038	0.08	0.20	0.30	0.31	0.70	8	2			1	2	5	6	10	1	0	1	10	88	500
SVY - MediMaps	77089	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or	10	0.036	0.027	0.12	0.15	0.30	0.49	0.70	11	3			1	3	4	8	10	4	20	88	200	995	1200
REC	77089	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk		0.022	0.022			0.20			9	2					5			2					

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	77085	XXX	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including	13	0.021	0.021			0.30			14	3					8			3					
2nd REF	77081	XXX	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius,	11	0.022	0.022			0.20			9	2					5			2					
CURRENT			N/A																							
SVY	77092	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional	33	0.042	0.033	0.08	0.20	0.30	0.32	4.00	9	2			1	3	5	6	10	2	0	0	10	73	960
SVY - Random	77092	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk	7	0.042	0.033	0.20	0.25	0.30	0.40	4.00	9	2			3	3	5	6	9	2	0	0	0	50	100
SVY - Subset	77092	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk	16	0.047	0.038	0.08	0.20	0.30	0.30	0.60	8	2			1	2	5	8	10	1	0	0	6	38	300
SVY - MediMaps	77092	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk	10	0.029	0.025	0.10	0.15	0.25	0.49	0.70	10	3			1	3	4	6	10	3	0	0	45	350	960
REC	77092	XXX	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional		0.022	0.022			0.20			9	2					5			2					

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 77089, 77090, 77091, 77092**

SPECIALTY SOCIETY: ACR

PRESENTER(S): Kurt A. Schoppe, MD; Lauren Golding, MD; Andy Moriarity, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
77089	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk (Do not report 77089 in conjunction with 77090, 77091, 77092)	XXX
77090	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere (Do not report 77090, 77091, 77092 in conjunction with 77089)	XXX
77091	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only (Do not report 77090, 77091, 77092 in conjunction with 77089)	XXX
77092	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by other qualified healthcare professional (Do not report 77090, 77091, 77092 in conjunction with 77089)	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
77089	A 69-year-old female who had a previous bone density study, which demonstrated osteopenia.
77090	A 54-year-old postmenopausal female with current tobacco use, a family history of osteoporosis, and a suspicion of Type II diabetes.
77091	A 75-year-old male with bilateral knee osteoarthritis and a history of use of corticosteroids.
77092	A 60-year-old female with antecedent of breast cancer treated with anti-aromatase.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The American College of Radiology convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for Trabecular Bone Score (TBS).

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   These is a new code family and does not have existing inputs. We have included CPT code 77081 *(Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular*

skeleton (peripheral) (eg, radius, wrist, heel)) as a reference code as TBS is commonly performed with (or uses) DXA scans.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   N/A

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   To note: As these are new codes, the specialty is using CPT code 77081 *(Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel))* as a reference as TBS is commonly performed with (or uses) DXA scans.

   According to the RUC database in the non-facility (Global & 26), Internal Medicine is the dominant specialty at 28.7%. The subsequent specialties are as follows: Diagnostic Radiology (23.8%), Endocrinology (15.2%), Rheumatology (10%), Family Medicine (8.9%), etc. Internal Medicine remains the dominant specialty in the Global as well.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   This is a new code family. There are no existing inputs.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

   This is a new code family. There are no existing inputs.

9. Please provide a brief description of the clinical staff work for the following:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

a. Pre-Service period:

77090: The technologist sends the DXA scan image files offsite for external analysis.

77089 and 77090: The radiologic technologist provides pre-service education and obtains consent from the patient. The technologist explains the TBS procedure to patient before it is performed, informs the patient that this procedure is an add-on to DXA, and explains that this is a bone quality test calculated by the software based on the patient's images. The technologist explains how they measure quality (internal bone structure), what additional information that the physician may receive and that this may affect treatment decisions following the physician's interpretation of results.

b. Service period (includes pre, intra and post):

77089 and 77091: The technologist prepares and manipulates the images for physician interpretation. The technologist QC's the images in PACS and checks all images. In addition, the technologist may review the examination with the interpreting physician. The technologist scans the exam documents into PACS and completes the exam in the RIS system to populate images into the work queue.

c. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

77089 and 77091: The technologist prepares and manipulates the images for physician interpretation. The technologist QC's the images in PACS and checks all images. In addition, the technologist may review the examination with the interpreting physician. The technologist scans the exam documents into PACS and completes the exam in the RIS system to populate images into the work queue.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

TBS iNsight Software: This software is required in order to appropriately perform the TBS procedures. This software uses spatial statistics to calculate the TBS from the gray-scale variograms from DXA or other imaging data such as an X-ray or projected CT image. The technologist prepares and manipulates the images for physician interpretation. The TBS report is then reviewed and interpreted by the physician to determine the bone quality and risk of future fracture and help guide decisions about the course of care for the patient.

This is a recent 2020 invoice for the TBS iNsight Software. This software is currently sold "per click" or per scan. As this is a single-use item, we have included this as a supply item and not an equipment item, which is typically accounted for by minutes used. The invoice depicts that this is a TBS iNsight 1-year License and covers a total of 100 scans. The total unit price for the license is $2,500; therefore, we are estimating the cost to be $25 per patient (or scan).

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No.

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Technologist PACS Workstation (ED050) =PACS formula
Professional PACS Workstation (ED053) = Sum of half of pre-service physician time and full intra-service physician time

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

77081

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	K	M	O	Q
1	RUC Practice Expense Spreadsheet					REFERENCE CODE	RECOMMENDED	RECOMMENDED	RECOMMENDED	RECOMMENDED
2						77081	77089	77090	77091	77092
3		*RUC Collaboration Website*				Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by
4	Clinical Activity Code	Meeting Date: January 2021 Revision Date (if applicable): Tab: 19 Specialty: ACR	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute					
5		LOCATION				Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 16.74	$ 29.21	$ 1.64	$ 28.02	$ 0.36
8		TOTAL CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	30.0	9.0	4.0	7.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	3.0	2.0	4.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	27.0	7.0	0.0	7.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				$ 12.30	$ 3.69	$ 1.64	$ 2.87	$ -
13		PRE-SERVICE PERIOD								
14		Start: Following visit when decision for surgery/procedure made								
15	CA001	Complete pre-service diagnostic and referral forms	L041B	Radiologic Technologist	0.41			2		
16	CA002	Coordinate pre-surgery services (including test results)								
17	CA003	Schedule space and equipment in facility								
18	CA004	Provide pre-service education/obtain consent	L041B	Radiologic	0.41		2	2		
19	CA005	Complete pre-procedure phone calls and prescription								
20	CA006	Confirm availability of prior images/studies	L041B	Radiologic	0.41	2				
21	CA007	Review patient clinical extant information and questionnaire	L041B	Radiologic	0.41	1				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)								
29		End: When patient enters office/facility for surgery/procedure								
30		SERVICE PERIOD								
31		Start: When patient enters office/facility for surgery/procedure:								
32		Pre-Service (of service period)								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L041B	Radiologic	0.41	3				
34	CA010	Obtain vital signs								
35	CA011	Provide education/obtain consent	L041B	Radiologic	0.41	2				
36	CA012	Review requisition, assess for special needs								
37	CA013	Prepare room, equipment and supplies	L041B	Radiologic	0.41	2				
38	CA014	Confirm order, protocol exam								
39	CA015	Setup scope (nonfacility setting only)								
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L041B	Radiologic	0.41	2				
41	CA017	Sedate/apply anesthesia								
48		Intra-service (of service period)								
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)								
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)								
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)								
52	CA021	Perform procedure/service---NOT directly related to physician work time	L041B	Radiologic Technologist	0.41	10	2		2	

	A	B	D	E	F	G	K	M	O	Q
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**	**RECOMMENDED**	**RECOMMENDED**	**RECOMMENDED**	**RECOMMENDED**
2						**77081**	**77089**	**77090**	**77091**	**77092**
3		***RUC Collaboration Website***				**Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (DXA) or other imaging data on gray-**	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of**	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only**	**Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk only, by**
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 19 Specialty: ACR**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 16.74**	**$ 29.21**	**$ 1.64**	**$ 28.02**	**$ 0.36**
8		**TOTAL CLINICAL STAFF TIME**	L041B	Radiologic Technologist	0.41	**30.0**	**9.0**	**4.0**	**7.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L041B	Radiologic Technologist	0.41	**3.0**	**2.0**	**4.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L041B	Radiologic Technologist	0.41	**27.0**	**7.0**	**0.0**	**7.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L041B	Radiologic Technologist	0.41	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
58		**Post-Service (of service period)**								
59	CA022	Monitor patient following procedure/service, multitasking 1:4								
60	CA023	Monitor patient following procedure/service, no multitasking								
61	CA024	Clean room/equipment by clinical staff	L041B	Radiologic Technologist	0.41	3				
62	CA025	Clean scope								
63	CA026	Clean surgical instrument package								
64	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions								
65	CA028	Review/read post-procedure x-ray, lab and pathology reports								
66	CA029	Check dressings, catheters, wounds								
67	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L041B	Radiologic Technologist	0.41	2	**2**		**2**	
68	CA031	Review examination with interpreting MD/DO	L041B	Radiologic Technologist	0.41	2	**2**		**2**	
69	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	L041B	Radiologic Technologist	0.41	1	**1**		**1**	
70	CA033	Perform regulatory mandated quality assurance activity (service								
71	CA034	document procedure (non-PACS) (e.g. mandated reporting, registry								
72	CA035	Review home care instructions, coordinate visits/prescriptions								
73	CA036	Discharge day management				**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
80		**End: Patient leaves office/facility**								
81		**POST-SERVICE PERIOD**								
82		**Start: Patient leaves office/facility**								
83	CA037	Conduct patient communications								
84	CA038	Coordinate post-procedure services								
98		**End: with last office visit before end of global period**								
99	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
100		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 0.10**	**$ 25.00**	**$ -**	**$ 25.00**	**$ -**
101	SB036	paper, exam table	0.014	foot		7				
102	NEW	TBS iNsight Software	25	Per individual software scan			**1**		**1**	
109	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
110		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 4.34**	**$ 0.52**	**$ -**	**$ 0.15**	**$ 0.36**
111	ED050	Technologist PACS workstation	5557	PACS	0.022018		**7**		**7**	
112	ED053	Professional PACS Workstation	15255	PACS	0.060443		**6**			**6**
113	ER019	densitometry unit, fan beam, DXA (w-computer hardward & software)	67339		0.255149	17				

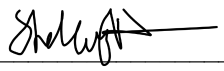
AMA/Specialty Society RVS Update Committee (RUC)
Vendor/Company Attestation Statement

This form needs to be completed by an authorized representative of any **Vendor or Company** that makes, markets or distributes a product or device utilized in performing the service being surveyed by the AMA/Specialty Society RVS Update Committee (RUC), as part of its CPT® code survey and valuation process, and which has supplied a list of users of such products or devices in connection with the survey and valuation process.

By submitting to the RUC a list of users of the undersigned's product or device as part of the RUC's CPT® code survey and valuation process, I attest that no employee, affiliate, or agent of the undersigned has contacted, and further covenant that they will not contact, any such user in connection with the survey. I hereby represent and warrant that I have the authority to sign this statement on behalf of the undersigned company and that the information herein is true and accurate. I understand that any false or inaccurate information will render the survey invalid, harming both the undersigned and the physicians who use the product or device.

Trabecular Bone Score
CPT® Codes

Medimaps Group
Vendor/Company Name

By: 

Shelley Horn
Printed Signature

Chief Business Development Officer
Title

October 22, 2020
Date

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS-Other – Utilization over 20,000

January 2021

Pathology Clinical Consult – Tab 20

The Relativity Assessment Workgroup identified CPT code 80500 via the CMS/Other source codes with the Medicare utilization over 20,000 screen. In October 2019, the RUC referred this issue to the CPT Editorial Panel to define this service more specifically as the current descriptor is vague. In October 2020, the CPT Editorial Panel replaced two codes with four new codes to report pathology clinical consultation and creation of guidelines to select and document the appropriate level of service.

Compelling Evidence
These services are exactly work neutral based on the utilization assumptions for the to be deleted codes, 80500 and 80502, to the new services. However, to account for any fluctuations and recognizing change in these services since CMS valued them, the specialty societies provided compelling evidence. The specialty society indicated that incorrect assumptions were made in the previous valuation of this service, physician work has changed due to technology advances and the patient population has changed. These services were valued via an unknown CMS crosswalk method over 30 years ago. This represents a flawed valuation assumption methodology. This code is a CMS/Other source code and has never been RUC surveyed or reviewed by the RUC. In the last 30 years, there has been an explosive growth in the number and complexity of laboratory tests, development of new drugs, and increased numbers of patients living with chronic diseases. Consequently, the role of the consulting pathologist to investigate and explain these issues has similarly grown and become more complex. Patients are frequently more complex with several chronic conditions and on multiple drugs. Disease classification systems are now more complex requiring integration of several patient and laboratory parameters including molecular studies. The quantity of data that needs to be assessed and incorporated into a comprehensive meaningful report is extensive. Additionally, transplant and pre-transplant consultations are more complex. With this growth, the spectrum of complex interpretations and consultations has also widened. As a result of these trends, there is greater demand for a written order and written report by the pathologist.

With respect to the explosive growth of laboratory tests and changes in population, molecular diagnostic testing has dramatically increased, which makes it difficult for ordering physicians to keep pace with the indications for and interpretations of the tests. In addition to an increase in molecular diagnostic testing, the number and complexity of laboratory testing has increased. Similarly, there is tremendous variability in the naming and abbreviations for test names, which can make selecting the appropriate test even more difficult. With so many test options available, there is an increased risk of an ordering physician selecting the wrong or unnecessary test which may delay making a diagnosis, impose risks on the patient, and impose other costs. To avoid this scenario, the necessity to consult a clinical pathologist before choosing which laboratory tests to order has increased.

The RUC determined that compelling evidence has been met that this service was previously valued based on a flawed methodology, the physician work has changed due to technology advances and the patient population has changed.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

A CMS representative questioned if the pathologist work in these services is more like a standard consultation service based on the description of work provided. The description of work has elements similar to the non-pathology consultation services, such as pre-service work for review of medical records and post-service work to confer findings with the clinical team. The Chair of the Research Subcommittee indicated that this question did come to the Research Subcommittee and the specialties indicated the difference was that because these services are not a direct patient to pathologist face-to-face encounter, but rather a provider to the pathologist encounter regarding a patient, the activities as they described them occurred in one continuous sitting. In other words, a provider calls the pathologists and he or she at that moment is looking through the previous studies, the history, providing the recommendation and then it all was one single intra-service encounter.

A CMS representative also questioned, that in the medical decision making (MDM) grid, to bump up to another level is the assessment requiring an independent historian. In the office visit MDM table, the independent historian could be a caregiver. Since none of that is described in the description of physician work, what is the relevance here for medical decision making for the pathologist? The specialty society indicated that the definition of independent witness here could be anyone, including a nurse. When a pathologist calls to get independent information, they may call and talk to a nurse and that would qualify as an independent historian.

80503 ***Pathology clinical consultation; for a clinical problem with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.***
The RUC reviewed the survey results from 53 pathologists and determined that the survey 25th percentile work RVU of 0.50 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes intra-service time. The RUC agreed that work per unit of time (WPUT) is stable across this family of services and comparable to other XXX codes with this amount of physician time.

The RUC compared CPT code 80503 to the top two key reference services, CPT code 85060 *Blood smear, peripheral, interpretation by physician with written report* (work RVU = 0.45 and 12 minutes intra-service time) and 88305 *Level IV Surgical Pathology* (work RVU = 0.75 and 25 minutes intra-service time), which appropriately bracket the recommended physician work and time for this service.

For additional support, the RUC referenced MPC code 99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU = 0.50 and 15 minutes total time) and code 99422 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes* (work RVU = 0.50 and 15 minutes total time), which require the exact same physician work and time. **The RUC recommends a work RVU of 0.50 for CPT code 80503.**

80504 ***Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.***
The RUC reviewed the survey results from 54 pathologists and determined that the survey 25th percentile work RVU of 0.91 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC agreed that work per unit of time (WPUT) is stable across this family of services and comparable to other XXX codes with this amount of physician time.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC compared CPT code 80504 to the top two key reference services, CPT 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU = 1.63 and 50 minutes intra-service time) and 85390 *Fibrinolysins or coagulopathy screen, interpretation and report* (work RVU = 0.75 and 20 minutes intra-service time), which appropriately bracket the recommended physician work and time for this service.

For additional support, the RUC referenced MPC codes 92012 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient* (work RVU = 0.92 and 25 minutes total time) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93 and 20 minutes total time), which require similar physician work and time. **The RUC recommends a work RVU of 0.91 for CPT code 80504.**

80505 ***Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.***
The RUC reviewed the survey results from 54 pathologists and determined that the survey 25th percentile work RVU of 1.80 appropriately accounts for the work required to perform this service. The RUC recommends 54 minutes intra-service time. The RUC agreed that work per unit of time (WPUT) is stable across this family of service and comparable to other XXX codes with this amount of physician time.

The RUC compared CPT code 80505 to the top two key reference services, 88325 *Consultation, comprehensive, with review of records and specimens, with report on referred material* (work RVU = 2.85 and 90 minutes intra-service time) and 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU = 1.63 and 50 minutes intra-service time), which appropriately bracket the recommended physician work and time for this service.

For additional support, the RUC referenced MPC codes 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU = 1.82 and 40 minutes total time) and 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU = 1.99 and 60 minutes total time) and 36456 *Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn*, (work RVU = 2.00 and 60 minutes total time), all which require similar physician work and time. **The RUC recommends a work RVU of 1.80 for CPT code 80505.**

80506 ***Pathology clinical consultation; prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 pathologists and determined that the survey 25th percentile work RVU of 0.80 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC agreed that work per unit of time (WPUT) is stable across this family of service and comparable to other XXX codes with this amount of physician time.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC compared CPT code 80506 to the top two key reference services, 88189 *Flow cytometry, interpretation; 16 or more markers* (work RVU = 1.70 and 36 minutes intra-service time) and 88356 *Morphometric analysis; nerve* (work RVU = 2.80 and 90 minutes intra-service time, both which require more physician work, time and intensity that the surveyed code.

For additional support, the RUC referenced MPC ZZZ codes 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65 and 30 minutes total time), 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 15 minutes total time) and 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)* (work RVU = 0.80 and 16 minutes total time). **The RUC recommends a work RVU of 0.80 for CPT code 80506.**

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

Practice Expense
The Practice Expense Subcommittee agreed that there is compelling evidence that the practice expense has changed due to this service being previously valued based on a flawed methodology, technology advances and change in the patient population (as specified in the compelling evidence that physician work has changed). The PE Subcommittee removed the equipment item ED021 *computer, desktop, w-monitor*, as it is not specifically dedicated to the procedure. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Pathology and Laboratory **Pathology Clinical Consultations ~~(Clinical Pathology)~~** Physician review of pathology and laboratory findings is frequently performed in the course of providing care to patients. Review of pathology and laboratory test results occurs in conjunction with the provision of an evaluation and management (E/M) service. Considered part of the non-face-to-face time activities associated with the overall E/M service, the review of the pathology and laboratory results is not a separately reportable service. Communicating results to the patient/family/caregiver of independent interpretation of results (not separately reported) may constitute an E/M service.				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Pathology clinical consultation services codes (80503, 80504, 80505, 80506) describe physician pathology services provided at the request of another physician or other qualified health care professional at the same or another facility or institution.

A ~~clinical~~ pathology clinical consultation is a service, including a written report, rendered by the pathologist in response to a request (eg, written request, electronic request, phone request or face-to-face request) from a physician or other qualified health care professional that relates to clinical assessment or evaluation of ~~in relation~~ pathology and laboratory findings or other relevant clinical or diagnostic information, ~~to a test result(s)~~ requiring additional medical interpretive judgment. Reporting of ~~a test result(s)~~ pathology and laboratory findings or other relevant clinical or diagnostic information, without medical interpretive judgment is not considered a ~~clinical~~ pathology clinical consultation.

~~Reporting of a test result(s), without medical interpretive judgment is not considered a clinical pathology consultation.~~

The pathology clinical consultation services (80503, 80504, 80505, 80506) may be reported when the following criteria have been met:

- The pathologist renders a pathology clinical consultation at the request of a physician or other qualified healthcare professional (QHP) at the same or another institution.
- The pathology clinical consultation request is in relation to pathology and laboratory findings or other relevant clinical or diagnostic information (eg, radiology findings or operative/procedural notes) requiring additional medical interpretative judgment.

A pathologist may also render a pathology clinical consultation when mandated by federal or state regulation (eg, Clinical Laboratory Improvement Amendments [CLIA]).

Instruction for Selecting a Level of Pathology Clinical Consultation Services

The appropriate level of pathology clinical consultation services may be based on either

the total time for pathology clinical consultation services performed on the date of the consultation;

or

the level of the medical decision making as defined for each service

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed * - Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Elements of Medical Decision Making Risk of Complications and/or Morbidity or Mortality of Patient Management	
80503	Low	Low • 1 to 2 laboratory or pathology findings or • 2 or more self-limited problems	Limited (Must meet the requirements of at least 1 of the 2 categories: Category 1: Tests and documents Any combination of 2 from the following: • Review of prior note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering or recommending additional or follow-up testing Or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment	
80504	Moderate	Moderate • 3 to 4 laboratory or	Moderate (Must meet the requirements of at least 1 out of 3 categories)	Moderate risk of morbidity from additional diagnostic	

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		pathology findings or • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms;	Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering or recommending additional or follow-up testing • Assessment requiring an independent historian(s) Or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); Or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	testing or treatment *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	
80505	High	High • 5 or more laboratory or pathology findings or • 1 or more chronic illnesses with severe exacerbation,	Extensive (Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior note(s) from each	High risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Drug therapy requiring intensive monitoring for	

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

			progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	unique source*; • Review of the result(s) of each unique test*; • Ordering or recommending additional or follow-up testing; • Assessment requiring an independent historian(s) Or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); Or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization	

Time

Time alone may be used to select the appropriate code level for the pathology clinical consultation services codes (ie, 80503, 80504, 80505). When time is used to select the appropriate level for pathology clinical consultation codes, time is defined by the service descriptions. When prolonged time occurs, the add-on code (80506) may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Total time on the date of the consultation (pathology clinical consultation services): For coding purposes, time for these services is the total time on the date of the consultation. It includes time personally spent by the consultant on the day of the consultation (includes time in activities that require the consultant and does not include time in activities normally performed by clinical staff).

Consultant time includes the following activities, when performed:

- review of available medical history including presenting complaint, signs and symptoms, personal and family history

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

- review of results of tests
- review of all relevant past and current laboratory, pathology, and clinical findings
- arriving at a tentative conclusion/differential diagnosis
- comparison with previous study reports including radiographic reports, images as applicable, and results of other clinical testing
- ordering or recommending additional or follow-up testing
- referring and communicating with other health care professionals (not separately reported)
- counseling and educating the clinician or other qualified health care professional
- documenting clinical consultation report in the electronic or other health record

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~80500~~	-	~~Clinical pathology consultation; limited, without review of patient's history and medical records~~	~~XXX~~	N/A
~~80502~~	-	~~comprehensive, for a complex diagnostic problem, with review of patient's history and medical records~~ ~~(These codes may also be used for pharmacokinetic consultations)~~ (80500, 80502 have been deleted. For clinical pathology consultation, limited or comprehensive, see 80503, 80504, 80505, 80506)	~~XXX~~	N/A
● 80503	W1	Pathology clinical consultation; for a clinical problem with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation. (For consultations involving the examination and evaluation of the patient, see 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255)	XXX	0.50

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
● 80504	W2	for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation	XXX	0.91
● 80505	W3	for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation	XXX	1.80
✚● 80506	W4	prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure) (Use 80506 in conjunction with 80505) (Do not report 80503, 80504, 80505, 80506 in conjunction with 88321, 88323, 88325) (Prolonged pathology clinical consultation service of less than 15 additional minutes is not reported separately) (For consultations involving the examination and evaluation of the patient, see 99241-99255)	ZZZ	0.80

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:80503 Tracking Number Original Specialty Recommended RVU: **0.50**
Presented Recommended RVU: **0.50**
Global Period: XXX Current Work RVU: **N/A** RUC Recommended RVU: **0.50**

CPT Descriptor: Pathology clinical consultation; for a clinical problem with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation..

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 45-year-old female presents with abnormal pap smear. Clinicopathologic correlation of abnormal pap-smear with previous pap smears and/or gynecologic biopsies is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 62%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist is consulted by a provider on a patient. The pathologist reviews the clinical history in the patient’s medical record(s), which may include but is not limited to the history of present and past illness, medical/surgical history, imaging data, medication lists, transfusion history, social history and travel history. The patient’s medical record is reviewed focusing on recent and relevant remote clinical and diagnostic findings. All applicable diagnostic material, slides, primary analytical data are retrieved/unarchived for the pathologist’s examination and review. The pathologist assesses the relevant results or findings to include, but not limited to, hematology, coagulation, chemistry, microbiology, molecular and genetic studies, and/or any peripheral blood smear(s), cytopathologic, and histopathologic preparation(s). The pathologist integrates all data and information for clinical correlation and medical decision making, with documentation of the service in the medical record. The pathologist may also discuss case findings with requesting provider and/or clinical team (by phone, face to face, or virtually), including recommendations for additional testing and further clinical evaluation. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021		
Presenter(s):	Roger McLendon, MD, Swati Mehrortra, MD, Ronald McLawon, MD, Oksana Volod, MD, James Fink, MD, PhD, Andrew Hoofnagle, MD, PhD, and Michael Laposata, MD, PhD		
Specialty Society(ies):	College of American Pathologists (CAP)		
CPT Code:	80503		
Sample Size:	3500	**Resp N:**	53
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**45.00**	150.00	3000.00
Survey RVW:	0.25	0.50	**0.75**	0.90	1.70
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	10.00	**15.00**	18.00	32.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	80503	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
85060	XXX	0.45	**RUC Time**

CPT Descriptor Blood smear, peripheral, interpretation by physician with written report

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88305	XXX	0.75	**RUC Time**

CPT Descriptor Level IV - Surgical pathology

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99407	XXX	0.50	**RUC Time**	83,194

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99281	XXX	0.48	**RUC Time**	67,730

CPT Descriptor 2 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.

Other Reference CPT Code	Global	Work RVU	Time Source
99422	XXX	0.50	**RUC Time**

CPT Descriptor Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 20 **% of respondents:** 37.7 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 13.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 80503	Top Key Reference CPT Code: 85060	2nd Key Reference CPT Code: **88305**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	15.00	12.00	25.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**15.00**	**12.00**	**25.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	10%	60%	30%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	60%	35%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	16%	74%	10%
Physical effort required	30%	65%	5%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	55%	40%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	43%	43%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	86%	14%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	57%	29%
Physical effort required	0%	71%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	57%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Clinical pathology consultation services were identified for review by the AMA RUC's Relativity Assessment Workgroup during the October 2019 RUC meeting. As part of the review of the 80500-80502 code family, the CAP reviewed Medicare claims utilization data and observed that there may be confusion regarding proper reporting of these services or miscoding. The RUC agreed with the CAP's request to refer the code family to CPT to develop proper CPT instruction and a proposal for code structure refinement for the October 2020 CPT Editorial Panel meeting. To clarify appropriate use of the clinical pathology services, the CPT Editorial Panel approved the deletion of CPT codes 80500 and 80502

and the creation of four new pathology clinical consultation CPT codes for valuation by the RUC at the January 2021 RUC meeting.

Pathology Clinical Consultations
Physician review of pathology and laboratory findings is frequently performed in the course of providing care to patients. Review of pathology and laboratory test results occurs in conjunction with the provision of an evaluation and management (E/M) service. Considered part of the non-face-to-face time activities associated with the overall E/M service, the review of the pathology and laboratory results is not a separately reportable service.

Pathology clinical consultation services (80503, 80504, 80505, 80506) describe physician pathology clinical consultation services provided at the request of another physician or qualified health care professional at the same or another facility or institution.

A pathology clinical consultation is a service, including a written report, rendered by the pathologist in response to a request (eg, written request, electronic request, phone request or face-to-face request) from a physician or other qualified health care professional that relates to clinical assessment or evaluation of pathology and laboratory findings or other relevant clinical or diagnostic information, requiring additional medical interpretive judgment. Reporting of pathology and laboratory findings or other relevant clinical or diagnostic information, without medical interpretive judgment, is not considered a pathology clinical consultation.

The pathology clinical consultation services (80503, 80504, 80505, 80506) may be reported when the following criteria have been met:

- The pathologist renders a pathology clinical consultation at the request of a physician or qualified healthcare professional (QHP) at the same or another institution.
- The pathology clinical consultation request is in relation to pathology and laboratory findings or other relevant clinical or diagnostic information requiring additional medical interpretative judgment.

A pathologist may also render a pathology clinical consultation when mandated by federal or state regulation (eg, Clinical Laboratory Improvement Amendments [CLIA]). For example, CLIA 88 requires that at a minimum of all Pap test results interpreted as high grade squamous intraepithelial lesion (HSIL), adenocarcinoma or other malignant neoplasms be correlated with subsequent or previous histologic biopsies. Additionally, if a patient has a current HSIL (cervical intraepithelial neoplasia (CIN 2 and above) with prior negative pap test, CLIA 88 requires all gynecologic cytology slides over the last five years to be reviewed for that patient.

Instruction for Selecting a Level of Pathology Clinical Consultation Services
The appropriate level of pathology clinical consultation services may be based on either the total time for pathology clinical consultation services performed on the date of the consultation; or the level of the medical decision making as defined for each service.

Guidelines for Pathology Clinical Consultation Services
Select the appropriate level of pathology clinical consultation services based on the following:

1. The total time for pathology clinical consultation services performed on the date of the consultation; or
2. The level of the medical decision making as defined for each service.

Compelling Evidence:
The CAP's expert panel believes that the RUC's compelling evidence standards have been met for the following reasons:

Evidence that incorrect assumptions were made in the previous valuation of the service
There is evidence that incorrect assumptions were made in the previous valuation of this service. This service was valued through an unknown CMS crosswalk method about 25 years ago. This represents a flawed valuation assumption mechanism or methodology. This code is a CMS/Other source code and has never been RUC surveyed or reviewed by the RUC.

Evidence that technology has changed physician work (ie, diffusion of technology) and the patient population has changed
Over the past 25 years since these services were valued by CMS, there has been an explosive growth in the number and complexity laboratory tests, development of new drugs, and the increased numbers of patients living with chronic diseases. Some reasons for these increases are as follows:

- Relative to 25 years ago, hospitals now have a more varied and diverse population with new diseases that need to be looked for (eg. malaria, microfilaria, etc.).
- The presence of new diseases or more prevalent diseases with hematologic manifestations/findings (eg. babesia, anaplasmosis/ehrlichiosis, COVID, therapy-related myeloid disorders from more cancer patients

receiving chemotherapy, new medications leading to more hematologic disorders, typically cytopenias, more illegal drugs such as levamisole-tainted cocaine leading to neutropenia or other cytopenias).
- Coagulation has new tests and many new anticoagulants that make interpreting coagulation tests much more difficult.
- Toxicology has many new drugs and metabolites to detect and often needs to detected (ie., many patients do multiple drugs).
- For smear reviews, patient hospitalizations seem to be more complex with more health issues and longer hospital stays, on average.

Consequently, the role of the consulting pathologist to investigate and explain these issues has similarly grown. Patients are frequently more complex with several chronic conditions and on multiple drugs. Disease classification systems are now more complex requiring integration of several patient and laboratory parameters including molecular studies. The quantity of data that needs to be assessed and incorporated into a comprehensive meaningful report is extensive. Additionally, transplant and pre transplant consultations are more complex. With this growth, the spectrum of complex interpretations and consultations has also widened. As a result of all of these trends, there is greater demand for a written order and written report by the pathologist.

With respect to the aforementioned explosive growth of laboratory tests and changes in population, molecular diagnostic testing has dramatically increased, which makes it difficult for physicians to keep pace with the indications for and interpretations of the tests. In addition to an increase in molecular diagnostic testing, the number and complexity of laboratory testing has increased. Similarly, there is tremendous variability in the naming and abbreviations for test names, which can make selecting the appropriate test even more difficult. With so many test options available, there is an increased risk of a physician selecting the wrong or unnecessary test which may delay making a diagnosis, impose risks on the patient, and impose other costs. To avoid this scenario, the necessity to consult a clinical pathologist before choosing which laboratory tests to order has increased.

Documentation in the peer-reviewed literature or other reliable data that there have been changes in physician work:

See the following recently published articles:

- The Clinical Pathologist as Consultant (American Journal of Clinical Pathology, Vol. 135, No. 1, January 2011 https://academic.oup.com/ajcp/article/135/1/11/1765622
- Algorithmic Approach With Clinical Pathology Consultation Improves Access to Specialty Care for Patients With Systemic Lupus Erythematosus (American Journal of Clinical Pathology, Vol. 146, No. 3, September 2016 https://academic.oup.com/ajcp/article/146/3/312/1739821
- An Analysis of Clinical Consultation Activities in Clinical Pathology: Who Requests Help and Why (American Journal of Clinical Pathology, Vol. 142, No. 3, September 2014 https://academic.oup.com/ajcp/article/142/3/286/1760569
- The Isolated Prolonged PTT (American Journal of Hematology, Vol. 88, No. 1, January 2013), https://onlinelibrary.wiley.com/doi/full/10.1002/ajh.23285

Survey Process and Results – 80503

In preparation for the January 2021 RUC meeting, the College of American Pathologists (CAP) determined that there is no pre-service or post-service physician work involved in this service and that the standard pathology survey instrument needed editing to exclude pre- and post-service work questions. Additionally, because clinical pathology consultations are specialized pathologists' work, a change in the survey instrument's intra-service work description was needed. The RUC's Research Subcommittee approved all the changes to the survey instrument.

The CAP conducted a physician work survey of 3,500 randomly selected active members, resulting in 53 respondents. Survey respondents (62%) agreed that the vignette represented the typical patient. The survey results are below:

80503, N=53	Intra-Service and Total Time	Physician Work RVU
Low	4	0.25
25th Percentile	10	0.50
Median	15	0.75
75th Percentile	18	0.90
High	32	1.70

The survey instrument contained 25 reference codes for respondents to choose from to depict the most similar pathology service to 80503. The reference service list physician work RVUs ranged from 0.24 to 3.60.

The Key Reference Service codes were:
First 85060 - Blood smear, peripheral, interpretation by physician with written report (Work RVU = 0.45, 12 minutes intra and total time) 38%
Secondary 88305 – Level IV – Surgical pathology (Work RVU = 0.75, 25 minutes intra and total time) 13%

Note that 58% of the respondents chose a reference code with a work RVU greater than the recommended work RVU of 0.50 for 80503.

Expert Panel Review and Opinion:
The survey results for CPT code 80503 were reviewed by an expert panel consisting of CAP's Economic Affairs Committee physician members, including several experts who perform the service. The expert panel considered the total work, time, intensity, and complexity of the typical patient case, and agreed that the 25th percentile work value of 0.50 with a median time of 15 minutes is the appropriate value for the code based on the survey results, intra-service time, comparison to key reference services, IWPUT, and the relative value of other codes on the physician fee schedule. In addition, it is important to note that the AMA's billed together data of the number of unique occurrences (same day, same patient, same provider), is typically once for code 80500.

Recommendation:
The CAP recommends a physician work RVU of 0.50 for CPT code 80503 with 15 minutes of intra-service and total time. The expert panel believes that our survey supports our recommendation for this new CPT code service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 80500

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Sometimes

Specialty Clinical Laboratory How often? Rarely

Specialty Other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 87992
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumption that 100% of the current volume of CPT code 80500 will go to this code and 2019 RUC database Medicare volume represents about 25% of the total payer volume.

Specialty Pathology Frequency 73385 Percentage 83.39 %

Specialty Clinical Laboratory Frequency 13709 Percentage 15.57 %

Specialty Other Frequency 898 Percentage 1.02 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 21,998 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumption that 100% of the current volume of CPT code 80500 will go to this code, 2019 RUC database Medicare volume used.

Specialty Pathology Frequency 18346 Percentage 83.39 %

Specialty Clinical Laboratory Frequency 3427 Percentage 15.57 %

Specialty Other Frequency 224 Percentage 1.01 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Specialist

BETOS Sub-classification Level II:
Pathology

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number N/A

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 80500

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:80504 Tracking Number Original Specialty Recommended RVU: **0.91**
Presented Recommended RVU: **0.91**
Global Period: XXX Current Work RVU: **N/A** RUC Recommended RVU: **0.91**

CPT Descriptor: Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old female with new onset leukocytosis. Pathology clinical consultation is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist is consulted by a provider on a patient. The pathologist reviews the clinical history in the patient's medical record(s), which may include but is not limited to the history of present and past illness, medical/surgical history, imaging data, medication lists, transfusion history, social history and travel history. The patient's medical record is reviewed focusing on recent and relevant remote clinical and diagnostic findings. All applicable diagnostic material, slides, primary analytical data are retrieved/unarchived for the pathologist's examination and review. The pathologist assesses the relevant results or findings to include, but not limited to, hematology, coagulation, chemistry, microbiology, molecular and genetic studies, and/or any peripheral blood smear(s), cytopathologic, and histopathologic preparation(s). The pathologist integrates all data and information for clinical correlation and medical decision making, with documentation of the service in the medical record. The pathologist may also discuss case findings with requesting provider and/or clinical team (by phone, face to face, or virtually), including recommendations for additional testing and further clinical evaluation. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Roger McLendon, MD, Swati Mehrortra, MD, Ronald McLawon, MD, Oksana Volod, MD, James Fink, MD, PhD, Andrew Hoofnagle, MD, PhD, and Michael Laposata, MD, PhD					
Specialty Society(ies):	College of American Pathologists (CAP)					
CPT Code:	80504					
Sample Size:	3500	**Resp N:**	54			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**65.00**	200.00	3000.00	
Survey RVW:	0.50	0.91	**1.50**	1.80	7.75	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	18.00	30.00	**30.00**	35.00	60.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	80504	**Recommended Physician Work RVU: 0.91**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88321	XXX	1.63	**RUC Time**

CPT Descriptor Consultation and report on referred slides prepared elsewhere

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
85390	XXX	0.75	**RUC Time**

CPT Descriptor Fibrinolysins or coagulopathy screen, interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36440	XXX	1.03	**RUC Time**	1

CPT Descriptor 1 Push transfusion, blood, 2 years or younger

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78306	XXX	0.86	**RUC Time**	262,283

CPT Descriptor 2 Bone and/or joint imaging; whole body

Other Reference CPT Code	Global	Work RVU	Time Source
88375	XXX	0.91	**RUC Time**

CPT Descriptor Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 24.0 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 12.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 80504	Top Key Reference CPT Code: 88321	2nd Key Reference CPT Code: **85390**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	30.00	50.00	20.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**50.00**	**20.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	75%	25%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	75%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	92%	8%
Physical effort required	0%	83%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and	0%	67%	33%

judgment of physician • Estimated risk of malpractice suit with poor outcome					

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	14%	86%	0%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	57%	14%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	33%	67%	0%
Physical effort required	28%	71%	0%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	14%	57%	29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

See below

Clinical pathology consultation services were identified for review by the AMA RUC's Relativity Assessment Workgroup during the October 2019 RUC meeting. As part of the review of the 80500-80502 code family, the CAP reviewed Medicare claims utilization data and observed that there may be confusion regarding proper reporting of these services or miscoding. The RUC agreed with the CAP's request to refer the code family to CPT to develop proper CPT instruction and a proposal for code structure refinement for the October 2020 CPT Editorial Panel meeting. To clarify appropriate use of the clinical pathology services, the CPT Editorial Panel approved the deletion of CPT codes 80500 and 80502 and the creation of four new pathology clinical consultation CPT codes for valuation by the RUC at the January 2021 RUC meeting.

Pathology Clinical Consultations
Physician review of pathology and laboratory findings is frequently performed in the course of providing care to patients. Review of pathology and laboratory test results occurs in conjunction with the provision of an evaluation and management (E/M) service. Considered part of the non-face-to-face time activities associated with the overall E/M service, the review of the pathology and laboratory results is not a separately reportable service.

Pathology clinical consultation services (80503, 80504, 88505, 88506) describe physician pathology clinical consultation services provided at the request of another physician or qualified health care professional at the same or another facility or institution.

A pathology clinical consultation is a service, including a written report, rendered by the pathologist in response to a request (eg, written request, electronic request, phone request or face-to-face request) from a physician or other qualified health care professional that relates to clinical assessment or evaluation of pathology and laboratory findings or other relevant clinical or diagnostic information, requiring additional medical interpretive judgment. Reporting of pathology and laboratory findings or other relevant clinical or diagnostic information, without medical interpretive judgment, is not considered a pathology clinical consultation.

The pathology clinical consultation services (80503, 80504, 88505, 88506) may be reported when the following criteria have been met:

- The pathologist renders a pathology clinical consultation at the request of a physician or qualified healthcare professional (QHP) at the same or another institution.
- The pathology clinical consultation request is in relation to pathology and laboratory findings or other relevant clinical or diagnostic information requiring additional medical interpretative judgment.

A pathologist may also render a pathology clinical consultation when mandated by federal or state regulation (eg, Clinical Laboratory Improvement Amendments [CLIA]). For example, CLIA 88 requires that at a minimum of all Pap test results interpreted as high grade squamous intraepithelial lesion (HSIL), adenocarcinoma or other malignant neoplasms be correlated with subsequent or previous histologic biopsies. Additionally, if a patient has a current HSIL (cervical intraepithelial neoplasia (CIN 2 and above) with prior negative pap test, CLIA 88 requires all gynecologic cytology slides over the last five years to be reviewed for that patient.

Instruction for Selecting a Level of Pathology Clinical Consultation Services
The appropriate level of pathology clinical consultation services may be based on either
the total time for pathology clinical consultation services performed on the date of the consultation; or the level of the medical decision making as defined for each service.

Guidelines for Pathology Clinical Consultation Services
Select the appropriate level of pathology clinical consultation services based on the following:

1. The total time for pathology clinical consultation services performed on the date of the consultation; or
2. The level of the medical decision making as defined for each service.

Compelling Evidence:
The CAP's expert panel believes that the RUC's compelling evidence standards have been met for the following reasons:

Evidence that incorrect assumptions were made in the previous valuation of the service
There is evidence that incorrect assumptions were made in the previous valuation of this service. This service was valued through an unknown CMS crosswalk method about 25 years ago. This represents a flawed valuation assumption mechanism or methodology. This code is a CMS/Other source code and has never been RUC surveyed or reviewed by the RUC.

Evidence that technology has changed physician work (ie, diffusion of technology) and the patient population has changed
Over the past 25 years since these services were valued by CMS, there has been an explosive growth in the number and complexity laboratory tests, development of new drugs, and the increased numbers of patients living with chronic diseases. Some reasons for these increases are as follows:

- Relative to 25 years ago, hospitals now have a more varied and diverse population with new diseases that need to be looked for (eg. malaria, microfilaria, etc.).

- The presence of new diseases or more prevalent diseases with hematologic manifestations/findings (eg. babesia, anaplasmosis/ehrlichiosis, COVID, therapy-related myeloid disorders from more cancer patients receiving chemotherapy, new medications leading to more hematologic disorders, typically cytopenias, more illegal drugs such as levamisole-tainted cocaine leading to neutropenia or other cytopenias).
- Coagulation has new tests and many new anticoagulants that make interpreting coagulation tests much more difficult.
- Toxicology has many new drugs and metabolites to detect and often needs to detected (ie., many patients do multiple drugs).
- For smear reviews, patient hospitalizations seem to be more complex with more health issues and longer hospital stays, on average.

Consequently, the role of the consulting pathologist to investigate and explain these issues has similarly grown. Patients are frequently more complex with several chronic conditions and on multiple drugs. Disease classification systems are now more complex requiring integration of several patient and laboratory parameters including molecular studies. The quantity of data that needs to be assessed and incorporated into a comprehensive meaningful report is extensive. Additionally, transplant and pre transplant consultations are more complex. With this growth, the spectrum of complex interpretations and consultations has also widened. As a result of all of these trends, there is greater demand for a written order and written report by the pathologist.

With respect to the aforementioned explosive growth of laboratory tests and changes in population, molecular diagnostic testing has dramatically increased, which makes it difficult for physicians to keep pace with the indications for and interpretations of the tests. In addition to an increase in molecular diagnostic testing, the number and complexity of laboratory testing has increased. Similarly, there is tremendous variability in the naming and abbreviations for test names, which can make selecting the appropriate test even more difficult. With so many test options available, there is an increased risk of a physician selecting the wrong or unnecessary test which may delay making a diagnosis, impose risks on the patient, and impose other costs. To avoid this scenario, the necessity to consult a clinical pathologist before choosing which laboratory tests to order has increased.

Documentation in the peer-reviewed literature or other reliable data that there have been changes in physician work:

See the following recently published articles:

- The Clinical Pathologist as Consultant (American Journal of Clinical Pathology, Vol. 135, No. 1, January 2011 https://academic.oup.com/ajcp/article/135/1/11/1765622
- Algorithmic Approach With Clinical Pathology Consultation Improves Access to Specialty Care for Patients With Systemic Lupus Erythematosus (American Journal of Clinical Pathology, Vol. 146, No. 3, September 2016 https://academic.oup.com/ajcp/article/146/3/312/1739821
- An Analysis of Clinical Consultation Activities in Clinical Pathology: Who Requests Help and Why (American Journal of Clinical Pathology, Vol. 142, No. 3, September 2014 https://academic.oup.com/ajcp/article/142/3/286/1760569
- The Isolated Prolonged PTT (American Journal of Hematology, Vol. 88, No. 1, January 2013), https://onlinelibrary.wiley.com/doi/full/10.1002/ajh.23285

Survey Process and Results – 88504

In preparation for the January 2021 RUC meeting, the College of American Pathologists (CAP) determined that there is no pre-service or post-service physician work involved in this service and that the standard pathology survey instrument needed editing to exclude pre- and post-service work questions. Additionally, because clinical pathology consultations are specialized pathologists' work, a change in the survey instrument's intra-service work description was needed. The RUC's Research Subcommittee approved all the changes to the survey instrument.

The CAP conducted a physician work survey of 3,500 randomly selected active members, resulting in 54 respondents. Survey respondents (78%) agreed that the vignette represented the typical patient. The survey results are below:

88504, N=54	Intra-Service and Total Time	Physician Work RVU
Low	18	0.50
25th Percentile	30	0.91
Median	30	1.50
75th Percentile	35	1.80
High	60	7.75

The survey instrument contained 25 reference codes for respondents to choose from to depict the most similar pathology service to 88504. The reference service list physician work RVUs ranged from 0.24 to 3.60.

The Key Reference Service codes were:
First 88321 - Consultation and report on referred slides prepared elsewhere (Work RVU = 1.63, 50 minutes intra and total time) 24%
Secondary 85390 Fibrinolysins or coagulopathy screen, interpretation and report (Work RVU = 0.75, 20 minutes intra and total time) 13%
Note that 70% of the respondents chose a reference code with a work RVU greater than the recommended work RVU of 0.91 for 88504.

Expert Panel Review and Opinion:
The survey results for CPT code 88504 were reviewed by an expert panel consisting of CAP's Economic Affairs Committee physician members, including several experts who perform the service. The expert panel considered the total work, time, intensity, and complexity of the typical patient case, and agreed that the 25th percentile work value of 0.91 with a median time of 30 minutes is the appropriate value for the code based on the survey results, intra-service time, comparison to key reference services, IWPUT, and the relative value of other codes on the physician fee schedule. In addition, it is important to note that the AMA's billed together data of the number of unique occurrences (same day, same patient, same provider), is typically once for codes 80500 and 80502.

Recommendation:
The CAP recommends a physician work RVU of 0.91 for CPT code 88504 with 30 minutes of intra-service and total time. The expert panel believes that our survey supports our recommendation for this new CPT code service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 80502

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Sometimes

Specialty Clinical Laboratory How often? Rarely

Specialty Other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 41965
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumption that 80% of the current volume of CPT code 80502 will go to this code and 2019 RUC database Medicare volume represents about 25% of the total payer volume.

Specialty Pathology Frequency 35032 Percentage 83.47 %

Specialty Clinical Laboratory Frequency 6078 Percentage 14.48 %

Specialty Other Frequency 915 Percentage 2.18 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,491 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumption that 80% of the current Medicare volume of CPT code 80502 will go to this code, 2019 RUC database Medicare volume used.

Specialty Pathology Frequency 8758 Percentage 83.48 %

Specialty Clinical Laboratory Frequency 1504 Percentage 14.33 %

Specialty Other Frequency 229 Percentage 2.18 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Specialist

BETOS Sub-classification Level II:
Pathology

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number N/A

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 80502

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:80505 Tracking Number Original Specialty Recommended RVU: **1.80**
Presented Recommended RVU: **1.80**
Global Period: XXX Current Work RVU: **N/A** RUC Recommended RVU: **1.80**

CPT Descriptor: Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 41-year-old female with acute thrombocytopenia and anemia. Pathology clinical consultation is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist is consulted by a provider on a patient. The pathologist reviews the clinical history in the patient's medical record(s), which may include but is not limited to the history of present and past illness, medical/surgical history, imaging data, medication lists, transfusion history, social history and travel history. The patient's medical record is reviewed focusing on recent and relevant remote clinical and diagnostic findings. All applicable diagnostic material, slides, primary analytical data are retrieved/unarchived for the pathologist's examination and review. The pathologist assesses the relevant results or findings to include, but not limited to, hematology, coagulation, chemistry, microbiology, molecular and genetic studies, and/or any peripheral blood smear(s), cytopathologic, and histopathologic preparation(s). The pathologist integrates all data and information for clinical correlation and medical decision making, with documentation of the service in the medical record. The pathologist may also discuss case findings with requesting provider and/or clinical team (by phone, face to face, or virtually), including recommendations for additional testing and further clinical evaluation. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021		
Presenter(s):	Roger McLendon, MD, Swati Mehrortra, MD, Ronald McLawon, MD, Oksana Volod, MD, James Fink, MD, PhD, Andrew Hoofnagle, MD, PhD, and Michael Laposata, MD, PhD		
Specialty Society(ies):	College of American Pathologists (CAP)		
CPT Code:	80505		
Sample Size:	3500	**Resp N:**	54
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**25.00**	100.00	1200.00
Survey RVW:	0.75	1.80	**2.84**	2.90	6.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	50.00	**54.00**	60.00	75.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	80505	**Recommended Physician Work RVU: 1.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**54.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88325	XXX	2.85	**RUC Time**

CPT Descriptor Consultation, comprehensive, with review of records and specimens, with report on referred material

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88321	XXX	1.63	**RUC Time**

CPT Descriptor Consultation and report on referred slides prepared elsewhere

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99239	XXX	1.90	**RUC Time**	5,189,830

CPT Descriptor 1 Hospital discharge day management; more than 30 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99318	XXX	1.71	**RUC Time**	100,126

CPT Descriptor 2 Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
99340	XXX	1.80	**RUC Time**

CPT Descriptor Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care,

integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

---

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 **% of respondents:** 46.2 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 12.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 80505	Top Key Reference CPT Code: 88325	2nd Key Reference CPT Code: **88321**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	54.00	90.00	50.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**54.00**	**90.00**	**50.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	56%	36%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	52%	48%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	76%	24%
Physical effort required	8%	60%	32%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	44%	52%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	43%	43%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	43%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	43%	43%
Physical effort required	0%	100%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	14%	14%	71%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Clinical pathology consultation services were identified for review by the AMA RUC's Relativity Assessment Workgroup during the October 2019 RUC meeting. As part of the review of the 80500-80502 code family, the CAP reviewed Medicare claims utilization data and observed that there may be confusion regarding proper reporting of these services or miscoding. The RUC agreed with the CAP's request to refer the code family to CPT to develop proper CPT instruction and a proposal for code structure refinement for the October 2020 CPT Editorial Panel meeting. To clarify appropriate use of the clinical pathology services, the CPT Editorial Panel approved the deletion of CPT codes 80500 and 80502 and the creation of four new pathology clinical consultation CPT codes for valuation by the RUC at the January 2021 RUC meeting.

Pathology Clinical Consultations

Physician review of pathology and laboratory findings is frequently performed in the course of providing care to patients. Review of pathology and laboratory test results occurs in conjunction with the provision of an evaluation and management (E/M) service. Considered part of the non-face-to-face time activities associated with the overall E/M service, the review of the pathology and laboratory results is not a separately reportable service.

Pathology clinical consultation services (80503, 8006, 80505, 80506) describe physician pathology clinical consultation services provided at the request of another physician or qualified health care professional at the same or another facility or institution.

A pathology clinical consultation is a service, including a written report, rendered by the pathologist in response to a request (eg, written request, electronic request, phone request or face-to-face request) from a physician or other qualified health care professional that relates to clinical assessment or evaluation of pathology and laboratory findings or other relevant clinical or diagnostic information, requiring additional medical interpretive judgment. Reporting of pathology and laboratory findings or other relevant clinical or diagnostic information, without medical interpretive judgment, is not considered a pathology clinical consultation.

The pathology clinical consultation services (80503, 80504, 80505, 80506) may be reported when the following criteria have been met:

- The pathologist renders a pathology clinical consultation at the request of a physician or qualified healthcare professional (QHP) at the same or another institution.
- The pathology clinical consultation request is in relation to pathology and laboratory findings or other relevant clinical or diagnostic information requiring additional medical interpretative judgment.

A pathologist may also render a pathology clinical consultation when mandated by federal or state regulation (eg, Clinical Laboratory Improvement Amendments [CLIA]). For example, CLIA 88 requires that at a minimum of all Pap test results interpreted as high grade squamous intraepithelial lesion (HSIL), adenocarcinoma or other malignant neoplasms be correlated with subsequent or previous histologic biopsies. Additionally, if a patient has a current HSIL (cervical intraepithelial neoplasia (CIN 2 and above) with prior negative pap test, CLIA 88 requires all gynecologic cytology slides over the last five years to be reviewed for that patient.

Instruction for Selecting a Level of Pathology Clinical Consultation Services

The appropriate level of pathology clinical consultation services may be based on either
the total time for pathology clinical consultation services performed on the date of the consultation; or the level of the medical decision making as defined for each service.

Guidelines for Pathology Clinical Consultation Services

Select the appropriate level of pathology clinical consultation services based on the following:

1. The total time for pathology clinical consultation services performed on the date of the consultation; or
2. The level of the medical decision making as defined for each service.

Compelling Evidence:

The CAP's expert panel believes that the RUC's compelling evidence standards have been met for the following reasons:

Evidence that incorrect assumptions were made in the previous valuation of the service

There is evidence that incorrect assumptions were made in the previous valuation of this service. This service was valued through an unknown CMS crosswalk method about 25 years ago. This represents a flawed valuation assumption mechanism or methodology. This code is a CMS/Other source code and has never been RUC surveyed or reviewed by the RUC.

Evidence that technology has changed physician work (ie, diffusion of technology) and the patient population has changed

Over the past 25 years since these services were valued by CMS, there has been an explosive growth in the number and complexity laboratory tests, development of new drugs, and the increased numbers of patients living with chronic diseases. Some reasons for these increases are as follows:

- Relative to 25 years ago, hospitals now have a more varied and diverse population with new diseases that need to be looked for (eg. malaria, microfilaria, etc.).
- The presence of new diseases or more prevalent diseases with hematologic manifestations/findings (eg. babesia, anaplasmosis/ehrlichiosis, COVID, therapy-related myeloid disorders from more cancer patients receiving chemotherapy, new medications leading to more hematologic disorders, typically cytopenias, more illegal drugs such as levamisole-tainted cocaine leading to neutropenia or other cytopenias).
- Coagulation has new tests and many new anticoagulants that make interpreting coagulation tests much more difficult.
- Toxicology has many new drugs and metabolites to detect and often needs to detected (ie., many patients do multiple drugs).
- For smear reviews, patient hospitalizations seem to be more complex with more health issues and longer hospital stays, on average.

Consequently, the role of the consulting pathologist to investigate and explain these issues has similarly grown. Patients are frequently more complex with several chronic conditions and on multiple drugs. Disease classification systems are now more complex requiring integration of several patient and laboratory parameters including molecular studies. The quantity of data that needs to be assessed and incorporated into a comprehensive meaningful report is extensive. Additionally, transplant and pre transplant consultations are more complex. With this growth, the spectrum of complex interpretations and consultations has also widened. As a result of all of these trends, there is greater demand for a written order and written report by the pathologist.

With respect to the aforementioned explosive growth of laboratory tests and changes in population, molecular diagnostic testing has dramatically increased, which makes it difficult for physicians to keep pace with the indications for and interpretations of the tests. In addition to an increase in molecular diagnostic testing, the number and complexity of laboratory testing has increased. Similarly, there is tremendous variability in the naming and abbreviations for test names, which can make selecting the appropriate test even more difficult. With so many test options available, there is an increased risk of a physician selecting the wrong or unnecessary test which may delay making a diagnosis, impose risks on the patient, and impose other costs. To avoid this scenario, the necessity to consult a clinical pathologist before choosing which laboratory tests to order has increased.

Documentation in the peer-reviewed literature or other reliable data that there have been changes in physician work:

See the following recently published articles:

- The Clinical Pathologist as Consultant (American Journal of Clinical Pathology, Vol. 135, No. 1, January 2011 https://academic.oup.com/ajcp/article/135/1/11/1765622
- Algorithmic Approach With Clinical Pathology Consultation Improves Access to Specialty Care for Patients With Systemic Lupus Erythematosus (American Journal of Clinical Pathology, Vol. 146, No. 3, September 2016 https://academic.oup.com/ajcp/article/146/3/312/1739821
- An Analysis of Clinical Consultation Activities in Clinical Pathology: Who Requests Help and Why (American Journal of Clinical Pathology, Vol. 142, No. 3, September 2014 https://academic.oup.com/ajcp/article/142/3/286/1760569
- The Isolated Prolonged PTT (American Journal of Hematology, Vol. 88, No. 1, January 2013), https://onlinelibrary.wiley.com/doi/full/10.1002/ajh.23285

Survey Process and Results – 80505

In preparation for the January 2021 RUC meeting, the College of American Pathologists (CAP) determined that there is no pre-service or post-service physician work involved in this service and that the standard pathology survey instrument needed editing to exclude pre- and post-service work questions. Additionally, because clinical pathology consultations are specialized pathologists' work, a change in the survey instrument's intra-service work description was needed. The RUC's Research Subcommittee approved all the changes to the survey instrument.

The CAP conducted a physician work survey of 3,500 randomly selected active members, resulting in 54 respondents. Survey respondents (78%) agreed that the vignette represented the typical patient. The survey results are below:

80505, N=54	Intra-Service and Total Time	Physician Work RVU
Low	15	0.75
25th Percentile	50	1.80
Median	54	2.84

75th Percentile	60	2.90
High	75	6.00

The survey instrument contained 25 reference codes for respondents to choose from to depict the most similar pathology service to 80505. The reference service list physician work RVUs ranged from 0.24 to 3.60.

The Key Reference Service codes were:
First 88325 - Consultation, comprehensive, with review of records and specimens, with report on referred material (Work RVU = 2.85, 90 minutes intra and total time) 46%
Secondary 88321 – Consultation and report on referred slides prepared elsewhere (Work RVU = 1.63, 50 minutes intra and total time) 13%

Note that 57% of the respondents chose a reference code with a work RVU greater than the recommended work RVU of 1.80 for 80505.

Expert Panel Review and Opinion:
The survey results for CPT code 80505 were reviewed by an expert panel consisting of CAP's Economic Affairs Committee physician members, including several experts who perform the service. The expert panel considered the total work, time, intensity, and complexity of the typical patient case, and agreed that the 25th percentile work value of 1.80 with a median time of 54 minutes is the appropriate value for the code based on the survey results, intra-service time, comparison to key reference services, IWPUT, and the relative value of other codes on the physician fee schedule. In addition, it is important to note that the AMA's billed together data of the number of unique occurrences (same day, same patient, same provider), is typically once for codes 80500 and 80502.

Recommendation:
The CAP recommends a physician work RVU of 1.80 for CPT code 80505 with 54 minutes of intra-service and total time. The expert panel believes that our survey supports our recommendation for this new CPT code service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 80502

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Sometimes

Specialty Clinical Laboratory How often? Rarely

Specialty Other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 10491
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumption that 20% of the current volume of CPT code 80502 will go to this code and 2019 RUC database Medicare volume represents about 25% of the total payer volume.

Specialty Pathology Frequency 8758 Percentage 83.48 %

Specialty Clinical Laboratory Frequency 1504 Percentage 14.33 %

Specialty Other Frequency 229 Percentage 2.18 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,622
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumption that 20% of the current volume of CPT code 80502 will go to this code using 2019 RUC database Medicare volume.

Specialty Pathology Frequency 2190 Percentage 83.49 %

Specialty Clinical Laboratory Frequency 376 Percentage 14.33 %

Specialty Other Frequency 57 Percentage 2.17 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Specialist

BETOS Sub-classification Level II:
Pathology

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number N/A

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 80502

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:80506 Tracking Number Original Specialty Recommended RVU: **0.80**
Presented Recommended RVU: **0.80**
Global Period: ZZZ Current Work RVU: **N/A** RUC Recommended RVU: **0.80**

CPT Descriptor: Pathology clinical consultation; prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Assessment of patient with complex toxicology results. Pathology clinical consultation is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Continue the work of pathology consultation, lasting at least 15 minutes beyond the time of the 80505 service, that includes tasks such as assessing the additional relevant data and clinical information, with further analyses and medical decision making. The pathologist will document the prolonged service or increased complexity of medical decision making.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Roger McLendon, MD, Swati Mehrortra, MD, Ronald McLawon, MD, Oksana Volod, MD, James Fink, MD, PhD, Andrew Hoofnagle, MD, PhD, and Michael Laposata, MD, PhD					
Specialty Society(ies):	College of American Pathologists (CAP)					
CPT Code:	80506					
Sample Size:	3500	**Resp N:**	49			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**18.00**	119.00	3000.00	
Survey RVW:	0.25	0.80	**1.50**	2.00	3.60	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	12.00	27.00	**30.00**	60.00	120.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	80506	**Recommended Physician Work RVU: 0.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88189	XXX	1.70	**RUC Time**

CPT Descriptor Flow cytometry, interpretation; 16 or more markers

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
88356	XXX	2.80	**RUC Time**

CPT Descriptor Morphometric analysis; nerve

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36476	XXX	2.65	**RUC Time**	7,170

CPT Descriptor 1 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77002	XXX	0.54	**RUC Time**	528,759

CPT Descriptor 2 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
10004	XXX	0.80	**RUC Time**

CPT Descriptor Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 16.3 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 12.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 80506	Top Key Reference CPT Code: 88189	2nd Key Reference CPT Code: **88356**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	30.00	90.00	90.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**90.00**	**90.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	13%	50%	25%	13%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	38%	38%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	13%	50%	38%
Physical effort required	13%	75%	13%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	38%	38%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	50%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	50%
Physical effort required	0%	83%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Clinical pathology consultation services were identified for review by the AMA RUC's Relativity Assessment Workgroup during the October 2019 RUC meeting. As part of the review of the 80500-80502 code family, the CAP reviewed Medicare claims utilization data and observed that there may be confusion regarding proper reporting of these services

or miscoding. The RUC agreed with the CAP's request to refer the code family to CPT to develop proper CPT instruction and a proposal for code structure refinement for the October 2020 CPT Editorial Panel meeting. To clarify appropriate use of the clinical pathology services, the CPT Editorial Panel approved the deletion of CPT codes 80500 and 80502 and the creation of four new pathology clinical consultation CPT codes for valuation by the RUC at the January 2021 RUC meeting.

Pathology Clinical Consultations
Physician review of pathology and laboratory findings is frequently performed in the course of providing care to patients. Review of pathology and laboratory test results occurs in conjunction with the provision of an evaluation and management (E/M) service. Considered part of the non-face-to-face time activities associated with the overall E/M service, the review of the pathology and laboratory results is not a separately reportable service.

Pathology clinical consultation services (80503, 80504, 80505, 80506) describe physician pathology clinical consultation services provided at the request of another physician or qualified health care professional at the same or another facility or institution.

A pathology clinical consultation is a service, including a written report, rendered by the pathologist in response to a request (eg, written request, electronic request, phone request or face-to-face request) from a physician or other qualified health care professional that relates to clinical assessment or evaluation of pathology and laboratory findings or other relevant clinical or diagnostic information, requiring additional medical interpretive judgment. Reporting of pathology and laboratory findings or other relevant clinical or diagnostic information, without medical interpretive judgment, is not considered a pathology clinical consultation.

The pathology clinical consultation services (80503, 80504, 80505, 80506) may be reported when the following criteria have been met:

- The pathologist renders a pathology clinical consultation at the request of a physician or qualified healthcare professional (QHP) at the same or another institution.
- The pathology clinical consultation request is in relation to pathology and laboratory findings or other relevant clinical or diagnostic information requiring additional medical interpretative judgment.

A pathologist may also render a pathology clinical consultation when mandated by federal or state regulation (eg, Clinical Laboratory Improvement Amendments [CLIA]). For example, CLIA 88 requires that at a minimum of all Pap test results interpreted as high grade squamous intraepithelial lesion (HSIL), adenocarcinoma or other malignant neoplasms be correlated with subsequent or previous histologic biopsies. Additionally, if a patient has a current HSIL (cervical intraepithelial neoplasia (CIN 2 and above) with prior negative pap test, CLIA 88 requires all gynecologic cytology slides over the last five years to be reviewed for that patient.

Instruction for Selecting a Level of Pathology Clinical Consultation Services
The appropriate level of pathology clinical consultation services may be based on either
the total time for pathology clinical consultation services performed on the date of the consultation; or the level of the medical decision making as defined for each service.

Guidelines for Pathology Clinical Consultation Services
Select the appropriate level of pathology clinical consultation services based on the following:

1. The total time for pathology clinical consultation services performed on the date of the consultation; or
2. The level of the medical decision making as defined for each service.

Compelling Evidence:
The CAP's expert panel believes that the RUC's compelling evidence standards have been met for the following reasons:

Evidence that incorrect assumptions were made in the previous valuation of the service
There is evidence that incorrect assumptions were made in the previous valuation of this service. This service was valued through an unknown CMS crosswalk method about 25 years ago. This represents a flawed valuation assumption mechanism or methodology. This code is a CMS/Other source code and has never been RUC surveyed or reviewed by the RUC.

Evidence that technology has changed physician work (ie, diffusion of technology) and the patient population has changed
Over the past 25 years since these services were valued by CMS, there has been an explosive growth in the number and complexity laboratory tests, development of new drugs, and the increased numbers of patients living with chronic diseases. Some reasons for these increases are as follows:

- Relative to 25 years ago, hospitals now have a more varied and diverse population with new diseases that need to be looked for (eg. malaria, microfilaria, etc.).
- The presence of new diseases or more prevalent diseases with hematologic manifestations/findings (eg. babesia, anaplasmosis/ehrlichiosis, COVID, therapy-related myeloid disorders from more cancer patients receiving chemotherapy, new medications leading to more hematologic disorders, typically cytopenias, more illegal drugs such as levamisole-tainted cocaine leading to neutropenia or other cytopenias).
- Coagulation has new tests and many new anticoagulants that make interpreting coagulation tests much more difficult.
- Toxicology has many new drugs and metabolites to detect and often needs to detected (ie., many patients do multiple drugs).
- For smear reviews, patient hospitalizations seem to be more complex with more health issues and longer hospital stays, on average.

Consequently, the role of the consulting pathologist to investigate and explain these issues has similarly grown. Patients are frequently more complex with several chronic conditions and on multiple drugs. Disease classification systems are now more complex requiring integration of several patient and laboratory parameters including molecular studies. The quantity of data that needs to be assessed and incorporated into a comprehensive meaningful report is extensive. Additionally, transplant and pre transplant consultations are more complex. With this growth, the spectrum of complex interpretations and consultations has also widened. As a result of all of these trends, there is greater demand for a written order and written report by the pathologist.

With respect to the aforementioned explosive growth of laboratory tests and changes in population, molecular diagnostic testing has dramatically increased, which makes it difficult for physicians to keep pace with the indications for and interpretations of the tests. In addition to an increase in molecular diagnostic testing, the number and complexity of laboratory testing has increased. Similarly, there is tremendous variability in the naming and abbreviations for test names, which can make selecting the appropriate test even more difficult. With so many test options available, there is an increased risk of a physician selecting the wrong or unnecessary test which may delay making a diagnosis, impose risks on the patient, and impose other costs. To avoid this scenario, the necessity to consult a clinical pathologist before choosing which laboratory tests to order has increased.

Documentation in the peer-reviewed literature or other reliable data that there have been changes in physician work:

See the following recently published articles:

- The Clinical Pathologist as Consultant (American Journal of Clinical Pathology, Vol. 135, No. 1, January 2011 https://academic.oup.com/ajcp/article/135/1/11/1765622
- Algorithmic Approach With Clinical Pathology Consultation Improves Access to Specialty Care for Patients With Systemic Lupus Erythematosus (American Journal of Clinical Pathology, Vol. 146, No. 3, September 2016 https://academic.oup.com/ajcp/article/146/3/312/1739821
- An Analysis of Clinical Consultation Activities in Clinical Pathology: Who Requests Help and Why (American Journal of Clinical Pathology, Vol. 142, No. 3, September 2014 https://academic.oup.com/ajcp/article/142/3/286/1760569
- The Isolated Prolonged PTT (American Journal of Hematology, Vol. 88, No. 1, January 2013), https://onlinelibrary.wiley.com/doi/full/10.1002/ajh.23285

Survey Process and Results – 80506

In preparation for the January 2021 RUC meeting, the College of American Pathologists (CAP) determined that there is no pre-service or post-service physician work involved in this service and that the standard pathology survey instrument needed editing to exclude pre- and post-service work questions. Additionally, because clinical pathology consultations are specialized pathologists' work, a change in the survey instrument's intra-service work description was needed. The RUC's Research Subcommittee approved all the changes to the survey instrument.

The CAP conducted a physician work survey of 3,500 randomly selected active members, resulting in 58 respondents. Survey respondents (71%) agreed that the vignette represented the typical patient. The survey results are below:

80506, N=49	Intra-Service and Total Time	Physician Work RVU
Low	12	0.25
25th Percentile	27	0.80
Median	30	1.50

75th Percentile	60	2.00
High	120	3.60

The survey instrument contained 25 reference codes for respondents to choose from to depict the most similar pathology service to 80506. The reference service list physician work RVUs ranged from 0.24 to 3.60.

The Key Reference Service codes were:
First 88189 - Flow cytometry, interpretation; 16 or more markers (Work RVU = 1.70, 36 minutes intra and total time) 16%
Secondary 88356 – Morphometric analysis; nerve (Work RVU = 2.80, 90 minutes intra and total time) 12%
Note that 73% of the respondents chose a reference code with a work RVU greater than the recommended work RVU of 0.80 for 80506.

Expert Panel Review and Opinion:
The survey results for CPT code 80506 were reviewed by an expert panel consisting of CAP's Economic Affairs Committee physician members, including several experts who perform the service. The expert panel considered the total work, time, intensity, and complexity of the typical patient case, and agreed that the 25th percentile work value of 0.80 with a median time of 30 minutes is the appropriate value for the code based on the survey results, intra-service time, comparison to key reference services, IWPUT, and the relative value of other codes on the physician fee schedule. In addition, it is important to note that the AMA's billed together data of the number of unique occurrences (same day, same patient, same provider), is typically once for codes 80500 and 80502.

Recommendation:
The CAP recommends a physician work RVU of 0.80 for CPT code 80506 with 30 minutes of intra-service and total time. The expert panel believes that our survey supports our recommendation for this new CPT code service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Not reported in the past

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology How often? Sometimes

Specialty Clinical Laboratory How often? Rarely

Specialty Other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1049
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 10% of the estimated volume for 80505, (10% of current volume of 80502), using 2019 RUC Database volume.

Specialty Pathology Frequency 876 Percentage 83.50 %

Specialty Clinical Pathology Frequency 150 Percentage 14.29 %

Specialty Other Frequency 23 Percentage 2.19 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 262
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 10% of the estimated volume for 80505 (10% of current volume of 80502), using 2019 RUC Database volume.

Specialty Pathology Frequency 219 Percentage 83.58 %

Specialty Clinical Laboratory Frequency 38 Percentage 14.50 %

Specialty Other Frequency 6 Percentage 2.29 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Specialist

BETOS Sub-classification Level II:
Pathology

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number N/A

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 80502

ISSUE: Pathology Clinical Consultation Services

TAB: 20

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF	85060	XXX	Blood smear, peripheral, interpretation by physician with written report	20	0.038	0.038			0.45			12						12			
2nd REF	88305	XXX	Level IV Surgical Pathology	7	0.030	0.030			0.75			25						25			
CURRENT	80500	XXX	Clinical pathology consultation; limited, without review of patient's history and medical records		0.028	0.028			0.37			13						13			
SVY	80503	XXX	Pathology clinical consultation; for a clinical problem with limited review of patient's history and medical records and straightforward medical decision	53	0.050	0.050	0.25	0.50	0.75	0.90	1.70	15				4	10	15	18	32	
REC	80503	XXX	Pathology clinical consultation; for a clinical problem with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.		0.033	0.033			0.50			15						15			

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF	88321	XXX	Consultation and report on referred slides prepared elsewhere	13	0.033	0.033			1.63			50						50			
2nd REF	85390	XXX	Fibrinolysins or coagulopathy screen, interpretation and report	7	0.038	0.038			0.75			20						20			
CURRENT	80502	XXX	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records		0.032	0.032			1.33			42						42			
SVY	80504	XXX	Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of	54	0.050	0.050	0.50	0.91	1.50	1.80	7.75	30				18	30	30	35	60	
REC	80504	XXX	Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.		0.030	0.030			0.91			30						30			

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF	88325	XXX	Consultation, comprehensive, with review of records and specimens, with report on referred material	25	0.032	0.032			2.85			90						90			
2nd REF	88321	XXX	Consultation and report on referred slides prepared elsewhere	7	0.033	0.033			1.63			50						50			
CURRENT	80502	XXX	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records		0.032	0.032			1.33			42						42			
SVY	80505	XXX	Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high	54	0.053	0.053	0.75	1.80	2.84	2.90	6.00	54				15	50	54	60	75	
REC	80505	XXX	Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.		0.033	0.033			1.80			54						54			

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF	88189	XXX	Flow cytometry, interpretation; 16 or more markers	8	0.047	0.047			1.70			36						36			
2nd REF	88356	XXX	Morphometric analysis; nerve	6	0.031	0.031			2.80			90						90			
CURRENT	80502	XXX	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records		0.032	0.032			1.33			42						42			
SVY	80506	ZZZ	Pathology clinical consultation; prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)	49	0.050	0.050	0.25	0.80	1.50	2.00	3.60	30				12	27	30	60	120	
REC	80506	ZZZ	Pathology clinical consultation; prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)		0.027	0.027			0.80			30						30			

FACILITY DIRECT PE INPUTS **CPT CODES:80503-80506**

SPECIALTY SOCIETY(IES): College of American Pathologists

PRESENTER(S): Roger McLendon, MD; Ronald McLawhon, MD, PhD; Swati Mehrotra; MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
80503	Pathology clinical consultation; for a clinical problem with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.	XXX
80504	Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.	XXX
80505	Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.	XXX
80506	Pathology clinical consultation; prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
80503	45-year-old female presents with abnormal pap smear. Clinicopathologic correlation of abnormal pap-smear with previous pap smears and/or gynecologic biopsies is performed.
80504	A 45-year-old female with new onset leukocytosis. Pathology clinical consultation is requested.
80505	A 41-year-old female with acute thrombocytopenia and anemia. Pathology clinical consultation is requested.
80506	Assessment of patient with complex toxicology results. Pathology clinical consultation is requested.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The CAP recommends no direct practice expense inputs in the facility setting at this time.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   N/A

3. Is this code(s) typically reported with an E/M service?

   N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
   The CAP recommends no direct practice expense inputs in the facility setting at this time.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:
   The CAP recommends no direct practice expense inputs in the facility setting at this time.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:
   N/A

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:
   The CAP recommends no direct practice expense inputs in the facility setting at this time.
   b. Service period (includes pre, intra and post):
   The CAP recommends no direct practice expense inputs in the facility setting at this time.
   c. Post-service period:
   The CAP recommends no direct practice expense inputs in the facility setting at this time.
8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
   The CAP recommends no direct practice expense inputs in the facility setting at this time.

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
   N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

13. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

14. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

15. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NON-FACILITY DIRECT PE INPUTS **CPT CODES:80503-80506**

SPECIALTY SOCIETY(IES): College of American Pathologists

PRESENTER(S): Roger McLendon, MD; Ronald McLawhon, MD, PhD; Swati Mehrotra; MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
80503	Pathology clinical consultation; for a clinical problem with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.	XXX
80504	Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.	XXX
80505	Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.	XXX
80506	Pathology clinical consultation; prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignettes
80503	45-year-old female presents with abnormal pap smear. Clinicopathologic correlation of abnormal pap-smear with previous pap smears and/or gynecologic biopsies is performed.
80504	A 45-year-old female with new onset leukocytosis. Pathology clinical consultation is requested.
80505	A 41-year-old female with acute thrombocytopenia and anemia. Pathology clinical consultation is requested.
80506	Assessment of patient with complex toxicology results. Pathology clinical consultation is requested.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A consensus panel consisting of RUC advisors and subject matter experts met via multiple conference calls to review the survey data and existing PE inputs to develop the final recommendations presented in the PE worksheet.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   (Reference) CPT code 88323 - Consultation and report on referred material requiring preparation of slides

(Current inputs included on PE spreadsheet) CPT code 80500 - Clinical pathology consultation; limited, without review of patient's history and medical records
(Current inputs included on PE spreadsheet) CPT code 80502 - Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   These codes are not reported with an E/M service and are most often reported in the facility setting.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Pathology provides this service 83 percent of the time. Moreover, pathologists and clinical laboratories provide virtually 100 percent of this service. Pathology is also the dominant provider for this global service. The vast majority of these services are performed in the facility setting.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   The CAP's expert panel believes that the RUC's compelling evidence standards have been met for the following reasons:

   Evidence that incorrect assumptions were made in the previous valuation of the service
   There is evidence that incorrect assumptions were made in the previous valuation of this service. This service was valued through an unknown CMS crosswalk method about 25 years ago. This represents a flawed valuation assumption mechanism or methodology. This code is a CMS/Other source code and has never been RUC surveyed or reviewed by the RUC.

   Evidence that technology has changed physician work (ie, diffusion of technology) and the patient population has changed
   Over the past 25 years since these services were valued by CMS, there has been an explosive growth in the number and complexity of laboratory tests, development of new drugs, and the increased numbers of patients living with chronic diseases. Some reasons for these increases are as follows:
   - Relative to 25 years ago, hospitals now have a more varied and diverse population with new diseases that need to be looked for (eg. malaria, microfilaria, etc.).

- The presence of new diseases or more prevalent diseases with hematologic manifestations/findings (eg. babesia, anaplasmosis/ehrlichiosis, COVID, therapy-related myeloid disorders from more cancer patients receiving chemotherapy, new medications leading to more hematologic disorders, typically cytopenias, more illegal drugs such as levamisole-tainted cocaine leading to neutropenia or other cytopenias).
- Coagulation has new tests and many new anticoagulants that make interpreting coagulation tests much more difficult.
- Toxicology has many new drugs and metabolites to detect and often needs to detected (ie., many patients do multiple drugs).
- For smear reviews, patient hospitalizations seem to be more complex with more health issues and longer hospital stays, on average.

Consequently, tthe role of the consulting pathologist to investigate and explain these issues has similarly grown. Patients are more frequently more complex with several chronic conditions and on multiple drugs. Disease classification systems are now more complex requiring integration of several patient and laboratory parameters including molecular studies. The quantity of data that needs to be assessed and incorporated into a comprehensive meaningful report is extensive. Additionally, transplant and pre transplant consultations are more complex. With this growth, the spectrum of complex interpretations and consultations has also widened. As a result of all of these trends, there is greater demand for a written order and written report by the pathologist.

With respect to the aforementioned explosive growth of laboratory tests and changes in population, molecular diagnostic testing has dramatically increased, which makes it difficult for physicians to keep pace with the indications for and interpretations of the tests. In addition to an increase in molecular diagnostic testing, the number and complexity of laboratory testing has increased. Similarly, there is tremendous variability in the naming and abbreviations for test names, which can make selecting the appropriate test even more difficult. With so many test options available, there is an increased risk of a physician selecting the wrong or unnecessary test which may delay making a diagnosis, impose risks on the patient, and impose other costs. To avoid this scenario, the necessity to consult a clinical pathologist before choosing which laboratory tests to order has increased.

Documentation in the peer-reviewed literature or other reliable data that there have been changes in physician work:

See the following recently published articles:

- The Clinical Pathologist as Consultant (American Journal of Clinical Pathology, Vol. 135, No. 1, January 2011 https://academic.oup.com/ajcp/article/135/1/11/1765622
- Algorithmic Approach With Clinical Pathology Consultation Improves Access to Specialty Care for Patients With Systemic Lupus Erythematosus (American Journal of Clinical Pathology, Vol. 146, No. 3, September 2016 https://academic.oup.com/ajcp/article/146/3/312/1739821
- An Analysis of Clinical Consultation Activities in Clinical Pathology: Who Requests Help and Why (American Journal of Clinical Pathology, Vol. 142, No. 3, September 2014 https://academic.oup.com/ajcp/article/142/3/286/1760569

- The Isolated Prolonged PTT (American Journal of Hematology, Vol. 88, No. 1, January 2013), https://onlinelibrary.wiley.com/doi/full/10.1002/ajh.23285

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

N/A

   b. Service period (includes pre, intra and post):

5 minutes: Preservice of service period. Manage pre-evaluation activities

4 minutes; Preservice of service period. Accession and enter information

3 minutes: Post Service Service period. File specimen, supplies, and other materials

   c. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

5 minutes: Preservice of service period. Manage pre-evaluation activities: Clinical staff work done at this time is the compiling of patient data for the pathologist. Patient data can come from inside and/or outside of the physician's office and need to be integrated into the analyses performed by the pathologist. Additionally, data can come from other departmental areas and other specialists. Such data includes but is not limited to patient medical history records, retrieval of patient specimen slides, laboratory data, images, and printed/copied material. Electronic Health Records (EHR) and Laboratory Information Systems (LIS) are referenced as well. Data is often presented in graphical form which can be accessed via imaging software or may be printable for the pathologist.

4 minutes; Preservice of service period. Accession and enter information; The patient case is accessioned; multiple existing forms of data will need to be identified and incorporated into this accession.

3 minutes: Post Service Service period. File specimen, supplies, and other materials; Clinical staff files reports and slides and refills supplies and other materials used in the analysis

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
    N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
    N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
    N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):
    N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?

c. Does the computer include code specific software that is typically used to provide the service(s)?

A. Yes, the computer houses and/or accesses all the data and information that is integral to the pathologist's analyses.
B. During the time period when the pathologist is conducting his or her analysis, the computer is used exclusively by the pathologist; that is, no one else can use the computer when the pathologist is using it.
C. Yes. The computer contains the LIS suite of programs that allow for the analysis of laboratory data, retrieval of files and imaging data, images of laboratory data, such as graphical representations, and whole slide imaging as applicable to the office.

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

The CAP recommends the "Other" equipment formula for ED021 computer, desktop, w-monitor.
The CAP recommends the "Other" equipment formula EP024 microscope, compound.
ED021 and EP024 are used exclusively by the pathologist during the entire service and therefore the pathologist uses ED021 and EP024 during the entire duration of the service. The CAP used total median physician time from the work survey.

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is

reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**	
2						**88323**		**80500**	
3		***RUC Collaboration Website***				Consultation and report on referred material requiring preparation of slides		Clinical pathology consultation; limited, without review of patient's history and medical records	
4	**Clinical Activity Code**	**Meeting Date: January 13, 2021 Revision Date (if applicable): Tab: 20 Specialty: College of American Pathologists**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 29.50**	**$ -**	**$ 2.96**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**33.0**	**0.0**	**8.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**				**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L035A	Lab Tech/Histotechnologist	0.35	**11.0**	**0.0**	**8.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037B	Histotechnologist	0.37	**10.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L033A	Lab Technician	0.33	**12.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**				**0.0**	**0.0**	**0.0**	**0.0**
14		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 11.51**	**$ -**	**$ 2.96**	**$ -**
31		**End: When patient enters office/facility for surgery/procedure**							
32		**SERVICE PERIOD**							
33		**Start: When patient enters office/facility for surgery/procedure:**							
34		**Pre-Service (of service period)**							
35	PA009	Manage pre-evaluation activities	L035A	Lab Tech/Histotechnologist	0.35				
41	PA001	Accession and enter information	L035A	Lab Tech/Histotechnologist	0.35	11			
42		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37				
43		**Intra-service (of service period)**							
44	CA021	Perform procedure/service---NOT directly related to physician work time	L035A	Lab Tech/Histotechnologist	0.37			8	
45	PA009	Manage pre-evaluation activities	L037B	Histotechnologist	0.37	3			
46	PA012	Prepare supplies	L033A	Lab Technician	0.33	8			
47	PA004	Cleaning	L033A	Lab Technician	0.33	2			
48	PA011	Prepare slides	L037B	Histotechnologist	0.37	6			
51	PA013	Record results	L037B	Histotechnologist	0.37	1			
52	PA008	File specimen, supplies, and other materials	L033A	Lab Technician	0.33	2			
53		*Other activity: please include short clinical description here and type new in column A*							
54		**Post-Service (of service period)**							
55	PA008	File specimen, supplies, and other materials	L035A	Lab Tech/Histotechnologist	0.35				
56			L037D		0.37				
57		*Other activity: please include short clinical description here and type new in column A*	L037D		0.37				
60		**End: Patient leaves office/facility**							

	A	B	D	E	F	G	H	I	J
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**	
2						**88323**		**80500**	
3		***RUC Collaboration Website***				Consultation and report on referred material requiring preparation of slides		Clinical pathology consultation; limited, without review of patient's history and medical records	
4	**Clinical Activity Code**	**Meeting Date: January 13, 2021 Revision Date (if applicable): Tab: 20 Specialty: College of American Pathologists**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 29.50**	**$ -**	**$ 2.96**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**33.0**	**0.0**	**8.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**				**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L035A	Lab Tech/Histotechnologist	0.35	**11.0**	**0.0**	**8.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037B	Histotechnologist	0.37	**10.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L033A	Lab Technician	0.33	**12.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**				**0.0**	**0.0**	**0.0**	**0.0**
79	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**					
80		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 13.50**	**$ -**	**$ -**	**$ -**
81	SB023	gloves, non-sterile, nitrile	1.005	pair		2.0			
82	SB027	gown, staff, impervious	1.186	item		0.1			
83	SF004	blade, microtome	2.3883	item		0.2			
84	SL020	bleach	0.0077	ml		10.0			
85	SL030	cover slip, glass	0.079	item		2.0			
86	SL078	histology freezing spray (Freeze-It)	1.3508	oz		0.2			
87	SL085	label for microscope slides	0.1115	item		20.0			
88	SL095	mounting media (Histomount)	0.3838	ml		2.0			
89	SL120	slide container (for 20 microscope slides)	4.498	item		1.0			
90	SL122	slide, microscope	0.2838	item		2.0			
91	SL135	stain, hematoxylin	0.044	ml		16.0			
92	SL151	xylenes solvent	0.012	ml		60.0			
93	SL189	ethanol, 100%	0.0033	ml		60.0			
94	SL190	ethanol, 70%	0.0033	ml		8.0			
95	SL201	stain, eosin	0.0619	ml		8.0			
96	SL248	ethanol, 95%	0.0033	ml		36.0			
97	SM027	wipes, lens cleaning (per wipe) (Kimwipe)	0.0333	item		2.0			
98		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
100	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**				
101		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 4.49**	**$ -**	**$ -**	**$ -**
102	EP024	microscope, compound	9865.2588	Default	0.031841425	56			
103	ED021	computer, desktop, w-monitor	1624.4997		0.006436587				
104	EP033	slide coverslipper, robotic	45361	Default	0.142465728	6			
105	EP034	slide dryer	962.5	Default	0.002554212	1			
106	EP035	slide etcher-labeler	24764.871		0.079931891	1			
107	EP036	slide stainer, automated, high-volume throughput	31119.8729		0.097738483	12			
108	EP038	solvent recycling system	18913.2862		0.061045128	4			
109	EP043	water bath, general purpose (lab)	885.9762		0.002859605	6			
110	ER041	microtome	16502.4283		0.053263766	6			
111	EP019	hood, ventilator with blower			0.015871186	1			
112		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*							

	A	B	K	L	M	N	O	P	Q	R	S
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMM**
2			**80502**		**80503**		**80504**		**80505**		**80**
3		***RUC Collaboration Website***	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review		Pathology clinical consultation; for a clinical problem with limited review of patient's history and		Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's		Pathology clinical consultation; for a highly complex clinical problem, with comprehensive		Patholog consu prolonge each add minute
4	**Clinical Activity Code**	**Meeting Date: January 13, 2021** **Revision Date (if applicable):** **Tab: 20** **Specialty: College of American Pathologists**									
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 2.96**	**$ -**	**$ 4.68**	**$ -**	**$ 5.16**	**$ -**	**$ 5.92**	**$ -**	**$ 0.96**
8		**TOTAL CLINICAL STAFF TIME**	**8.0**	**0.0**	**12.0**	**0.0**	**12.0**	**0.0**	**12.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**8.0**	**0.0**	**12.0**	**0.0**	**12.0**	**0.0**	**12.0**	**0.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
14		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 2.96**	**$ -**	**$ 4.20**	**$ -**	**$ 4.20**	**$ -**	**$ 4.20**	**$ -**	**$ -**
31		**End: When patient enters office/facility for surgery/procedure**									
32		**SERVICE PERIOD**									
33		**Start: When patient enters office/facility for surgery/procedure:**									
34		**Pre-Service (of service period)**									
35	PA009	Manage pre-evaluation activities			5		5		5		
41	PA001	Accession and enter information			4		4		4		
42		*Other activity: please include short clinical description here and type new in column A*									
43		**Intra-service (of service period)**									
44	CA021	Perform procedure/service---NOT directly related to physician work time	8								
45	PA009	Manage pre-evaluation activities									
46	PA012	Prepare supplies									
47	PA004	Cleaning									
48	PA011	Prepare slides									
51	PA013	Record results									
52	PA008	File specimen, supplies, and other materials									
53		*Other activity: please include short clinical description here and type new in column A*									
54		**Post-Service (of service period)**									
55	PA008	File specimen, supplies, and other materials			3		3		3		
56											
57		*Other activity: please include short clinical description here and type new in column A*									
60		**End: Patient leaves office/facility**									

	A	B	K	L	M	N	O	P	Q	R	S
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMM
2			80502		80503		80504		80505		80
3		*RUC Collaboration Website*	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review		Pathology clinical consultation; for a clinical problem with limited review of patient's history and		Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's		Pathology clinical consultation; for a highly complex clinical problem, with comprehensive		Patholog consu prolonge each add minute
4	Clinical Activity Code	Meeting Date: January 13, 2021 Revision Date (if applicable): Tab: 20 Specialty: College of American Pathologists									
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 2.96	$ -	$ 4.68	$ -	$ 5.16	$ -	$ 5.92	$ -	$ 0.96
8		TOTAL CLINICAL STAFF TIME	8.0	0.0	12.0	0.0	12.0	0.0	12.0	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	8.0	0.0	12.0	0.0	12.0	0.0	12.0	0.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
12		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
13		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
79	Supply	MEDICAL SUPPLIES									
80		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
81	SB023	gloves, non-sterile, nitrile									
82	SB027	gown, staff, impervious									
83	SF004	blade, microtome									
84	SL020	bleach									
85	SL030	cover slip, glass									
86	SL078	histology freezing spray (Freeze-It)									
87	SL085	label for microscope slides									
88	SL095	mounting media (Histomount)									
89	SL120	slide container (for 20 microscope slides)									
90	SL122	slide, microscope									
91	SL135	stain, hematoxylin									
92	SL151	xylenes solvent									
93	SL189	ethanol, 100%									
94	SL190	ethanol, 70%									
95	SL201	stain, eosin									
96	SL248	ethanol, 95%									
97	SM027	wipes, lens cleaning (per wipe) (Kimwipe)									
98		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
100	Equipment Code	EQUIPMENT									
101		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ 0.48	$ -	$ 0.96	$ -	$ 1.72	$ -	$ 0.96
102	EP024	microscope, compound			15		30		54		30
103	ED021	computer, desktop, w-monitor			0		0		0		0
104	EP033	slide coverslipper, robotic									
105	EP034	slide dryer									
106	EP035	slide etcher-labeler									
107	EP036	slide stainer, automated, high-volume throughput									
108	EP038	solvent recycling system									
109	EP043	water bath, general purpose (lab)									
110	ER041	microtome									
111	EP019	hood, ventilator with blower									
112		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	T	U
1	**RUC Practice Expense Spreadsheet**		**MENDED**	
2			**506**	
3		***RUC Collaboration Website***	y clinical	
4	**Clinical Activity Code**	**Meeting Date: January 13, 2021** **Revision Date (if applicable):** **Tab: 20** **Specialty: College of American Pathologists**	tation; d service, itional 30 s (List	
5		**LOCATION**	**Facility**	
6		**GLOBAL PERIOD**	**ZZZ**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	
14		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	
31		**End: When patient enters office/facility for surgery/procedure**		
32		**SERVICE PERIOD**		
33		**Start: When patient enters office/facility for surgery/procedure:**		
34		**Pre-Service (of service period)**		
35	PA009	Manage pre-evaluation activities		
41	PA001	Accession and enter information		
42		*Other activity: please include short clinical description here and type new in column A*		
43		**Intra-service (of service period)**		
44	CA021	Perform procedure/service---NOT directly related to physician work time		
45	PA009	Manage pre-evaluation activities		
46	PA012	Prepare supplies		
47	PA004	Cleaning		
48	PA011	Prepare slides		
51	PA013	Record results		
52	PA008	File specimen, supplies, and other materials		
53		*Other activity: please include short clinical description here and type new in column A*		
54		**Post-Service (of service period)**		
55	PA008	File specimen, supplies, and other materials		
56				
57		*Other activity: please include short clinical description here and type new in column A*		
60		**End: Patient leaves office/facility**		

	A	B	T	U
1	**RUC Practice Expense Spreadsheet**		**MENDED**	
2			**506**	
3		***RUC Collaboration Website***	y clinical	
4	**Clinical Activity Code**	**Meeting Date: January 13, 2021** **Revision Date (if applicable):** **Tab: 20** **Specialty: College of American Pathologists**	tation; d service, itional 30 s (List	
5		**LOCATION**	**Facility**	
6		**GLOBAL PERIOD**	**ZZZ**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	
79	**Supply**	**MEDICAL SUPPLIES**		
80		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	
81	SB023	gloves, non-sterile, nitrile		
82	SB027	gown, staff, impervious		
83	SF004	blade, microtome		
84	SL020	bleach		
85	SL030	cover slip, glass		
86	SL078	histology freezing spray (Freeze-It)		
87	SL085	label for microscope slides		
88	SL095	mounting media (Histomount)		
89	SL120	slide container (for 20 microscope slides)		
90	SL122	slide, microscope		
91	SL135	stain, hematoxylin		
92	SL151	xylenes solvent		
93	SL189	ethanol, 100%		
94	SL190	ethanol, 70%		
95	SL201	stain, eosin		
96	SL248	ethanol, 95%		
97	SM027	wipes, lens cleaning (per wipe) (Kimwipe)		
98		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*		
100	**Equipment Code**	**EQUIPMENT**		
101		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	
102	EP024	microscope, compound		
103	ED021	computer, desktop, w-monitor		
104	EP033	slide coverslipper, robotic		
105	EP034	slide dryer		
106	EP035	slide etcher-labeler		
107	EP036	slide stainer, automated, high-volume throughput		
108	EP038	solvent recycling system		
109	EP043	water bath, general purpose (lab)		
110	ER041	microtome		
111	EP019	hood, ventilator with blower		
112		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*		

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Colon Capsule Endoscopy – Tab 21

In October 2020, the CPT Editorial Panel replaced one Category III code with a new Category I code to report gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report. Codes 91110 and 91111 were added as part of the family to be surveyed for the January 2021 RUC meeting.

91110 ***Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report***
The RUC reviewed the survey results from 104 gastroenterologists and agreed that the survey 25th percentile work RVU of 2.24 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 5 minutes of pre-service time, 40 minutes of intra-service time, and 10 minutes of immediate post-service time. During the intra-service period, which is intraluminal imaging of the esophagus through ileum, 70,000 images are captured. Specifically, the physician reviews the images with the localization software activated to input the esophagogastric junction, pylorus, and ileocecal valve locations. The physician scans the study and keys annotated anatomic landmarks (e.g., esophagogastric junction, duodenum, ileocecal valve, hepatic flexure, splenic flexure), permitting identification of potentially positive findings and determination of gastric and small bowel emptying times. Once the landmarks are determined, all images are viewed. When the physician identifies an abnormality, a thumbnail is created. Key findings or abnormalities are noted, and localization is determined by passage of time or by capsule localization software. The RUC agreed the intensity relativity is appropriate and that the recommended work value of 2.24 places the survey code well within the relativity of the family.

The RUC compared the survey code to the top key reference code 74262 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed* (work RVU= 2.50, intra-service time of 45 minutes and total time of 57 minutes) and noted that both codes have similar intra-service time and similar total time and should be valued similarly. Code 74262 has five additional minutes of intra-service time and two additional minutes of total time, which accounts for the higher work value. In addition, most of the survey respondents that selected the top key reference code had indicated either that the survey code has similar or more intensity (100% of those survey respondents that selected the top key reference code also rated the survey code identical to much more intense/complex), justifying similar IWPUTs and WPUTs for both services. Additionally, the RUC compared the survey code to code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material;* (work RVU= 2.35, intra-service time of 40 minutes, and total time of 60 minutes) and noted that both codes require identical intra-service time and very similar total time however, code 75557 has 5 more minutes of total time, supporting the work value for the survey code at the survey 25th percentile of 2.24. **The RUC recommends a work RVU of 2.24 for CPT code 91110.**

91111 ***Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report***
The RUC reviewed the survey results from 56 gastroenterologists and agreed that the current value of 1.00, which is below the survey 25th percentile, accurately reflects the typical physician work necessary to perform this service. The RUC recommends 5 minutes of pre-service time, 15 minutes of intra-service time, and 5 minutes of immediate post-service time. During the intra-service period, which is intraluminal imaging of

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

the esophagus, 15,000 images are captured. Specifically, the physician reviews the images and scans the entire study and annotated keys anatomic landmarks. Once the landmarks have been determined, all images are viewed by the physician. When an abnormality is identified, a thumbnail is created. The physician notes and records key findings or abnormalities on a localization drawing that may also be used to guide subsequent management of the patient. Localization is determined by passage of time or by capsule localization software. The RUC agreed that the intensity relativity is appropriate and that the recommended current work value of 1.00 places the survey code well within the relativity of the family.

The RUC compared the survey code to code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.27, pre-service time of 5 minutes, intra-service time of 15 minutes and post-service time of 4 minutes) and agreed that both codes have identical pre-service time, identical intra-service time, similar total time, and should be valued similarly. Code 70470 however, has one minute less of total time, supporting the recommended current value of 1.00 for the survey code. Additionally, the RUC compared the survey code to code 76391 *Magnetic resonance (eg, vibration) elastography* (work RVU= 1.10, pre-service time of 5 minutes, intra-service time of 15 minutes, and post-service time of 5 minutes) and MPC code 95819 *Electroencephalogram (EEG); including recording awake and asleep (*work RVU = 1.08, pre-service time of 5 minutes, intra-service time of 15 minutes, and post-service time of 6 minutes). **The RUC recommends a work RVU of 1.00 for CPT code 91111.**

91113 ***Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report***
The RUC reviewed the survey results from 58 gastroenterologists and agreed that the survey 25th percentile work RVU of 2.41 accurately reflects the typical physician work necessary to perform this service. The RUC recommends 5 minutes of pre-service time, 45 minutes of intra-service time, and 10 minutes of immediate post-service time. During the intra-service period, which is intraluminal imaging of the colon, 100,000 images are captured, reviewed and annotated. Specifically, the physician reviews the images with the localization software activated to input the esophagogastric junction, pylorus, and ileocecal valve locations. The physician scans the study and keys annotated anatomic landmarks (e.g., esophagogastric junction, first gastric image, first duodenal image, ileocecal valve, first cecal image, hepatic flexure, splenic flexure, and last rectal image), permitting identification of potentially positive findings and determination of gastric, small bowel and colonic transit times. Once the landmarks are identified, all images are then viewed with the two different (front and back) capsule cameras. This is in effect reviewing two capsule studies, one from the forward view camera and one from the trailing view camera. When the physician identifies an abnormality, it is measured, and a thumbnail is created. Images or abnormalities that are noted on the two different viewing cameras must be carefully analyzed and reconciled to determine if they represent two distinct pathologies or the same pathology from two different vantage points. This is critically important to avoid false positive findings. Localization is then determined by passage of time or by capsule localization software. The RUC agreed that intensity relativity is appropriate and that the recommended work value of 2.41 places the survey code well within the relativity of the family.

The RUC compared the survey code to the top key reference code 74262 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed* (work RVU = 2.50, pre-service time of 5 minutes, intra-service time of 45 minutes, and post-service time of 7 minutes) and noted that both codes have identical pre-service time, identical intra-service time, similar total time, and should be valued similarly. Most survey respondents (61%) who selected code 74262, rated the survey code more intense/complex, further supporting the survey 25th percentile work value of 2.41. Additionally, the RUC compared the survey code to MPC code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 2.40, intra-service time of 39 minutes, and total time of 57 minutes) and

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

noted that the survey code requires slightly more physician work and intra-service time and is therefore valued appropriately. **The RUC recommends a work RVU of 2.41 for CPT code 91113.**

New Technology/New Service
The RUC recommends that CPT code 91113 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The Practice Expense Subcommittee accepted the two new supplies 1 *PillCam® COLON 2 capsule* and *sensor sleeves* for code 91113 and removed SK087 *water, distilled*. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(f)91110	X1	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report (Do not report 91110 in conjunction with 91111, 91113, ~~0355T.~~0XX8T) (Incidental ~~V~~ visualization of the colon is not reported separately) (Append modifier 52 if the ileum is not visualized)	XXX	2.24 (2021 Work RVU = 2.49)
(f)91111	X2	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report (Do not report 91111 in conjunction with 91110, 91113,~~0355T~~ 0XX8T) (Incidental visualization of the stomach, duodenum ileum and/or colon is not reported separately) (For measurement of gastrointestinal tract transit times or pressure using wireless capsule, use 91112)	XXX	1.00 (No Change) (2021 Work RVU = 1.00)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

●91113	X3	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report (Do not report 91113 in conjunction with 91110, 91111) (Incidental visualization of the esophagus, stomach, duodenum, and/or ileum is not reported separately)	XXX	2.41
Category III Codes				
~~0355T~~	-	~~Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report~~ ~~(Use 0355T for imaging of distal ileum, when performed)~~ ~~(Do not report 0355T in conjunction with 91110, 91111)~~ (0355T has been deleted) (To report gastrointestinal tract imaging, intraluminal [eg, capsule endoscopy] of the colon, use 91113)	~~YYY~~	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

January 6, 2021

Peter K. Smith, MD
AMA Specialty/Society RVS Update Committee, Chair
AMA Department of Physician Payment Policy and Systems
330 North Wabash, Office 45-372
Chicago, IL 60611

Subject: Revised RVU recommendation for code 91113 - Tab 21

Dear Dr. Smith,

Based on feedback received during the RUC Pre-Facilitation #1 meeting on the evening of January 5 from our reviewers and the committee members, the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and the American Society for Gastroenterology (ASGE) wish to revise our physician work recommendation for CPT code 91113 (*Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report*).

Code 91113 is a new CPT code proposed by industry and approved at the October 2020 CPT Editorial Panel meeting to convert Category III code 0355T for colon capsule endoscopy to Category I. The ACG, AGA, and ASGE conducted a survey for the January 2021 RUC meeting and received 58 responses. Because the median experience for 91113 was 0, we provided a data breakdown in the Survey Summary Spreadsheet of those who reported performing the procedure in the past 12 months vs those who did not. Members of RUC Pre-facilitation #1 advised us also to provide the data breakdown for those who had performed the procedure in the past 5 years since the number of those who performed the procedure in the past 12 months did not meet the RUC's minimum survey response. There are 35 participants who reported performing 91113 in the past 5 years. ***Based on data from this cohort of experienced providers, we recommend a physician work RVU of 2.48 which is equal to the 25th percentile of their survey data.***

We also revised the intra-service and post-service physician work descriptions for 91113 as recommended by our reviewers to place the work of measuring abnormalities in the intra-service work description. The following changes are reflected in the revised SOR for 91113:

> **Intra-service:** The physician reviews the images with the localization software activated to input the esophagogastric junction, pylorus, and ileocecal valve locations. The physician scans the study and keys annotated anatomic landmarks (eg, esophagogastric junction, first

gastric image, first duodenal image, ileocecal valve, first cecal image, hepatic flexure, splenic flexure, and last rectal image), permitting identification of potentially positive findings and determination of gastric, small bowel and colonic transit times. Once the landmarks are determined, all images are then viewed with the two different capsule cameras (front and back). This is in effect reviewing two capsule studies, one from the forward view camera and one from the trailing view camera. When the physician identifies an abnormality, it is measured and a thumbnail is created. Key findings or abnormalities are noted. Images or abnormalities noted on the two different viewing cameras must be carefully analyzed and reconciled to determine if they represent two distinct pathologies or the same pathology from two different vantage points. This is critically important to avoid false positive findings. Localization is determined by passage of time or by capsule localization software.

Post-service: After all images are reviewed and an interpretation is formulated, the physician prepares a report. The findings are communicated to the patient~~, any abnormalities that are found are measured and communicated to the patient~~ and a copy of the report is sent to the referring physician. The referring physician may also be contacted to discuss the findings.

Attached please find the revised Summary of Recommendations form for 91113 and the revised Survey Summary Spreadsheet for Tab 21.

We look forward to discussing Tab 21 with the RUC at the January 2021 meeting.

Sincerely,



R. Bruce Cameron, MD
RUC Advisor
American College of Gastroenterology



Shivan Mehta, MD
RUC Advisor
American Gastroenterological Association



Seth A. Gross, MD
RUC Advisor
American Society for Gastrointestinal Endoscopy

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:91110 Tracking Number Original Specialty Recommended RVU: **2.24**
Presented Recommended RVU: **2.24**
Global Period: XXX Current Work RVU: **2.49** RUC Recommended RVU: **2.24**

CPT Descriptor: Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old patient with recurrent, obscure gastrointestinal bleeding not diagnosed by other imaging and endoscopic procedures is referred for evaluation. Wireless capsule endoscopy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The patient is assessed for possible contraindications such as presence of pacemaker, active bowel obstruction, or swallowing disorder. The patient is educated about the nature of the procedure, why it is being performed, and possible complications and is instructed on how to prepare for the procedure (eg, fasting and wearing the proper clothing).

Description of Intra-Service Work: The physician reviews the images with the localization software activated to input the esophagogastric junction, pylorus, and ileocecal valve locations. The physician scans the study and keys annotated anatomic landmarks (eg, esophagogastric junction, duodenum, ileocecal valve, hepatic flexure, splenic flexure), permitting identification of potentially positive findings and determination of gastric and small bowel emptying times. Once the landmarks are determined, all images are viewed. When the physician identifies an abnormality, a ôthumbnailö is created. Key findings or abnormalities are noted. Localization is determined by passage of time or by capsule localization software.

Description of Post-Service Work: After all images are reviewed and an interpretation is formulated, the physician prepares a report. The findings are communicated to the patient, and a copy of the report is sent to the referring physician. The referring physician may also be contacted to discuss the findings.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021
Presenter(s):	R. Bruce Cameron, MD, ACG Shivan Mehta, MD, AGA Patricia Garcia, MD, AGA Seth A. Gross, MD, ASGE Vivek Kaul, MD, ASGE
Specialty Society(ies):	American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy
CPT Code:	91110
Sample Size:	3416 **Resp N:** 104
Description of Sample:	With permission from the Research Subcommittee we conducted a targeted survey using data from the vendor on physicians who have performed colon capsule endoscopy. Originally, we understood the list would contain contact information for 520 physicians; however, the list we recived contained 449 physicians. We also conducted a random sample of 3000 of our societies' memberships; however, once the list was cross-checked with the email address in the industry list for duplicates and bad email addresses had been removed, the random sample was 2,967.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	12.00	**30.00**	51.00	1225.00
Survey RVW:	1.08	2.24	**2.56**	3.20	10.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	30.00	**40.00**	60.00	120.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	91110	**Recommended Physician Work RVU: 2.24**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)
XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74262	XXX	2.50	**RUC Time**

CPT Descriptor Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
91112	XXX	2.10	**RUC Time**

CPT Descriptor Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
88321	XXX	1.63	**RUC Time**	182,148

CPT Descriptor 1 Consultation and report on referred slides prepared elsewhere

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
75635	XXX	2.40	**RUC Time**	114,472

CPT Descriptor 2 Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 28 **% of respondents:** 26.9 **%**

Number of respondents who choose 2nd Key Reference Code: 25 **% of respondents:** 24.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 91110	Top Key Reference CPT Code: 74262	2nd Key Reference CPT Code: **91112**
Median Pre-Service Time	5.00	5.00	5.00
Median Intra-Service Time	40.00	45.00	40.00
Median Immediate Post-service Time	10.00	7.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**55.00**	**57.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	36%	43%	21%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4%	46%	50%

• Urgency of medical decision making	

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	39%	54%
Physical effort required	4%	54%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	46%	43%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	52%	44%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	12%	44%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	76%	20%
Physical effort required	0%	76%	24%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	52%	48%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel accepted a proposal from industry (Medtronic) presented at the October 2020 CPT Editorial Panel meeting to convert Category III code 0355T for colon capsule endoscopy to Category I. Colon capsule endoscopy is related to two other Category I CPT codes, capsule endoscopy of the small bowel (91110) and the esophagus (91111), which were last reviewed together by the RUC in January 2016. Codes 91110 and 91111 were surveyed with new CPT code 91113 by the ACG, AGA and ASGE.

The Research Subcommittee approved our proposed survey methodology to use both a targeted survey and random sample due to low performance cited by the applicant in the CPT application for colon capsule endoscopy (91113). The Research Subcommittee also provided input on our reference service list.

The ACG, AGA, and ASGE conducted a survey of existing CPT codes 91110 and 91111 and new CPT code 91113 for presentation at the January 2021 RUC meeting.

91110 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report

91111 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report

91113 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report

Our multi-specialty consensus panel reviewed the survey data for codes 91110, 91111 and 91113, comparing the data and work RVUs (wRVUs) to the current data for similar XXX-day global codes that were recently approved by the RUC.

91110 – Discussion and Recommendation

Code 91110 is an existing code that was last reviewed by the RUC in January 2016. The ACG, AGA, and ASGE conducted a survey for the January 2021 RUC meeting and received 104 responses (79 from the random sample and 25 from the targeted survey of the industry list).

We recommend a **wRVU of 2.24**. This value is equal to the 25th percentile of the combined survey data.

Pre-time Package XXX is appropriate with 5 minutes of evaluation time, reflecting the current pre-service time.

Pre-service evaluation time: 5 minutes
Pre-service positioning time: 0 minutes
Pre-service scrub, dress, wait time: 0 minutes

Post-time Package XXX is appropriate with of 10 minutes of immediate post-service time, reflecting the survey median.

Intra-service time of 40 minutes is appropriate, reflecting the survey median.

Key Reference Services

Two reference services were selected more often than others: 74262 and 91112. However, code 74262 (*Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed*) was selected most often (28/104).

Comparison to other recently RUC-reviewed codes with 40 minutes intra-service time:

CPT Code	Long Desc	Glob	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre Scrub, Dress, Wait Time	Intra Time	Imm Post Time	Total Time	Time Source	Most Recent RUC Review	Top_Specialty	IWPUT	MPC	2019 Medicare Util
77285	Therapeutic radiology simulatio	XXX	1.05	XXX	7			40	5	52	RUC	2013-01	DERMATOLOGY	0.0195		4612
92625	Assessment of tinnitus (include	XXX	1.15	XXX	7			40	10	57	RUC	2008-10	AUDIOLOGIST (IND.)	0.0192		9371
92597	Evaluation for use and/or fittin	XXX	1.26	XXX	7			40	13	60	RUC	2009-02	SLP	0.0203		2839
95928	Central motor evoked potential	XXX	1.50	XXX	15			40	10	65	RUC	2013-04	NEUROLOGY	0.0235		325
95929	Central motor evoked potential	XXX	1.50	XXX	15			40	10	65	RUC	2013-04	NEUROLOGY	0.0235		1333
75710	Angiography, extremity, unilate	XXX	1.75	XXX	15			40	15	70	RUC	2016-10	VASCULAR SURGERY	0.0269		157614
95863	Needle electromyography; 3 ext	XXX	1.87	XXX	10			40	11	61	RUC	2012-04	NEUROLOGY	0.035		157
95910	Nerve conduction studies; 7-8 s	XXX	2.00	XXX	13			40	12.5	65.5	RUC	2012-04	NEUROLOGY	0.0357		157766
91112	Gastrointestinal transit and pre	XXX	2.10	XXX	5			40	15	60	RUC	2012-04	GASTROENTEROLOGY	0.0413		1400
99183	Physician or other qualified hea	XXX	2.11	XXX	10			40	10	60	RUC	2014-01	GENERAL SURGERY	0.0415		386280
91110	Gastrointestinal tract imaging, i	XXX	2.24	XXX	5			40	10	55				0.048		53131
99386	Initial comprehensive preventiv	XXX	2.33	XXX	10			40	10	60	RUC	2010-10		0.047		
75557	Cardiac magnetic resonance im	XXX	2.35		10			40	10	60	RUC	2007-04	CARDIOLOGY	0.0475		3370
74261	Computed tomographic (CT) co	XXX	2.40		5			40	5	50	RUC	2009-04	DIAGNOSTIC RADIOLOGY	0.0544		8433
99336	Domiciliary or rest home visit fo	XXX	2.46		10			40	15	65	RUC	2007-02	NURSE PRACTITIONER	0.0475	Yes	1676057
99387	Initial comprehensive preventiv	XXX	2.50	XXX	10			40	15	65	RUC	2010-10		0.0485		
99234	Observation or inpatient hospit	XXX	2.56	XXX	14			40	15	69	RUC	2011-02	INTERNAL MEDICINE	0.0478		33757
99219	Initial observation care, per day	XXX	2.60	XXX	10			40	14.5	64.5	RUC	2010-10	INTERNAL MEDICINE	0.0513		674993
93315	Transesophageal echocardiogra	XXX	2.69	XXX	10			40	15	65	RUC	2014-04	CARDIOLOGY	0.0533		2359
95719	Electroencephalogram (EEG), co	XXX	3.00		10			40	10	60	RUC	2018-10		0.0638		
99291	Critical care, evaluation and ma	XXX	4.50		15			40	15	70	RUC	2005-08	EMERGENCY MEDICINE	0.0957	Yes	5905780

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 91110

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 98103

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2019 volume (32,701) * 3 = 98,103

Specialty Gastroenterology Frequency 92000 Percentage 93.77 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 32,701 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2019 volume

Specialty Gastroenterology Frequency 30500 Percentage 93.26 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Tests

BETOS Sub-classification:
Other tests

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 91110

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:91111 Tracking Number Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: XXX Current Work RVU: **1.00** RUC Recommended RVU: **1.00**

CPT Descriptor: Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old patient with cirrhosis and compromised liver function is referred for screening for esophageal varices. Wireless capsule endoscopy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The patient is assessed for possible contraindications, such as presence of pacemaker, active bowel obstruction, or swallowing disorder. The patient is educated about the nature of the procedure, why it is being performed, and possible complications and is instructed on how to prepare for the procedure (eg, fasting and wearing the proper clothing).

Description of Intra-Service Work: The physician reviews the images and scans the entire study and annotated keys anatomic landmarks (eg, esophagogastric junction). Once the landmarks have been determined, all images are viewed. When an abnormality is identified, a ôthumbnailö is created. The physician notes and records key findings or abnormalities on a localization drawing that may also be used to guide subsequent management of the patient. Localization is determined by passage of time or by capsule localization software.

Description of Post-Service Work: After all images are reviewed and an interpretation is formulated, the physician prepares a report. The findings are communicated to the patient, and a copy of the report is sent to the referring physician. The referring physician may also be contacted to discuss the findings.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021
Presenter(s):	R. Bruce Cameron, MD, ACG Shivan Mehta, MD, AGA Patricia Garcia, MD, AGA Seth A. Gross, MD, ASGE Vivek Kaul, MD, ASGE
Specialty Society(ies):	American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy
CPT Code:	91111
Sample Size:	3416 **Resp N:** 56
Description of Sample:	With permission from the Research Subcommittee we conducted a targeted survey using data from the vendor on physicians who have performed colon capsule endoscopy. Originally, we understood the list would contain contact information for 520 physicians; however, the list we recived contained 449 physicians. We also conducted a random sample of 3000 of our societies' memberships; however, once the list was cross-checked with the email address in the industry list for duplicates and bad email addresses had been removed, the random sample was 2,967.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	3.00	40.00
Survey RVW:	0.75	1.11	**2.00**	2.50	10.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**15.00**	28.00	75.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	91111	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)
XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
91112	XXX	2.10	**RUC Time**

CPT Descriptor Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74250	XXX	0.81	**RUC Time**

CPT Descriptor Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92012	XXX	0.92	**RUC Time**	6,617,899

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95819	XXX	1.08	**RUC Time**	202,028

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 16.0 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 14.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 91111	Top Key Reference CPT Code: 91112	2nd Key Reference CPT Code: 74250
Median Pre-Service Time	5.00	5.00	3.00
Median Intra-Service Time	15.00	40.00	15.00
Median Immediate Post-service Time	5.00	15.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**25.00**	**60.00**	**23.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	67%	22%	11%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	56%	33%	11%

• Urgency of medical decision making	

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	33%	56%	11%
Physical effort required	45%	44%	11%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	67%	11%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	38%	13%	50%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	50%	13%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	25%	38%	37%
Physical effort required	25%	38%	37%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	25%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel accepted a proposal from industry (Medtronic) presented at the October 2020 CPT Editorial Panel meeting to convert Category III code 0355T for colon capsule endoscopy to Category I. Colon capsule endoscopy is related to two other Category I CPT codes, capsule endoscopy of the small bowel (91110) and the esophagus (91111), which were last reviewed together by the RUC in January 2016. Codes 91110 and 91111 were surveyed with new CPT code 91113 by the ACG, AGA and ASGE.

The Research Subcommittee approved our proposed survey methodology to use both a targeted survey and random sample due to low performance cited by the applicant in the CPT application for colon capsule endoscopy (91113). The Research Subcommittee also provided input on our reference service list.

The ACG, AGA, and ASGE conducted a survey of existing CPT codes 91110 and 91111 and new CPT code 91113 for presentation at the January 2021 RUC meeting.

91110 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report

91111 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report

91113 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report

Our multi-specialty consensus panel reviewed the survey data for codes 91110, 91111 and 91113, comparing the data and work RVUs (wRVUs) to the current data for similar XXX-day global codes that were recently approved by the RUC.

91111 – Discussion and Recommendation

Code 91111 is an existing code that was last reviewed by the RUC in January 2016. The ACG, AGA, and ASGE conducted a survey for the January 2021 RUC meeting and received 56 responses (39 from the random sample and 17 from the targeted survey of the industry list).

We recommend a **wRVU of 1.00**. This value is equal to the current wRVU for 91111. The survey 25th percentile of the combined survey data is 1.11 wRVUs; however, we found no change in procedure, patient population or other compelling evidence requirement that would support an increase in wRVUs for 91111.

Pre-time Package XXX is appropriate with 5 minutes of evaluation time, reflecting the current pre-service time.

Pre-service evaluation time: 5 minutes
Pre-service positioning time: 0 minutes
Pre-service scrub, dress, wait time: 0 minutes

Post-time Package XXX is appropriate with of 5 minutes of immediate post-service time, reflecting the current post-service time.

Intra-service time of 15 minutes is appropriate, reflecting the survey median.

Key Reference Services

Two reference services were selected more often than others: 91112 and 74250. However, code 91112 (*Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report*) was selected most often (9/56).

Comparison to other recently RUC-reviewed codes with 15 minutes intra-service time:

CPT Code	Long Desc	Glob	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre Scrub, Dress, Wait Time	Intra Time	Imm Post Time	Total Time	Time Source	Most Recent RUC Review	Top_Specialty	IWPUT	MPC	2019 Medicare Util
92538	Caloric vestibular test with rec	XXX	0.30	XXX	5			15	5	25	RUC	2015-01	AUDIOLOGIST (IND.)	0.0051		6794
97610	Low frequency, non-contact, nc	XXX	0.40	XXX	6			15	5	26	RUC	2019-01	PODIATRY	0.0102		12331
97607	Negative pressure wound thera	XXX	0.41	XXX	3			15	5	23	RUC	2014-01	ORTHOPEDIC SURGER	0.0154		5825
97535	Self-care/home management tr	XXX	0.45	XXX	2.5			15	4	21.5	RUC	2017-01	OCCUPATIONAL THER	0.0203		1942480
97537	Community/work reintegration	XXX	0.48	XXX	5			15	5	25	RUC	2017-01	PHYSICAL THERAPIST (	0.0171		23275
97533	Sensory integrative techniques	XXX	0.48	XXX	3			15	5	23	RUC	2017-01	PHYSICAL THERAPIST (	0.0201		21250
97542	Wheelchair management (eg, a	XXX	0.48	XXX	3			15	5	23	RUC	2017-01	PHYSICAL THERAPIST (	0.0201		61278
97763	Orthotic(s)/prosthetic(s) manag	XXX	0.48	XXX	2.5			15	5	22.5	RUC	2017-01	OCCUPATIONAL THER	0.0208		38754
20561	Needle insertion(s) without inje	XXX	0.48		3			15	3	21	RUC	2019-01		0.023		
74400	Urography (pyelography), intra	XXX	0.49	XXX	5			15	5	25	RUC	2011-09	DIAGNOSTIC RADIOLO	0.0177		5180
98967	Telephone assessment and ma	XXX	0.50		1			15	5	21	RUC	2007-04		0.0244		
99151	Moderate sedation services pro	XXX	0.50	XXX				15	15	30	RUC	2015-10	EMERGENCY MEDICIN	0.0109		11
97760	Orthotic(s) management and tr	XXX	0.50	XXX	5			15	5	25	RUC	2017-01	OCCUPATIONAL THER	0.0184		57907
97761	Prosthetic(s) training, upper an	XXX	0.50	XXX	5			15	5	25	RUC	2017-01	PHYSICAL THERAPIST (	0.0184		2698
97129	Therapeutic interventions that	XXX	0.50		5			15	5	25	RUC	2019-01		0.0184		
93268	External patient and, when per	XXX	0.52	XXX	5			15	10	30	RUC	2010-04	CARDIOLOGY	0.0123		11689
93224	External electrocardiographic re	XXX	0.52	XXX	2			15	7	24	RUC	2010-04	CARDIOLOGY	0.0212	Yes	284557
93227	External electrocardiographic re	XXX	0.52	XXX	2			15	7	24	RUC	2010-04	CARDIOLOGY	0.0212		344162
74420	Urography, retrograde, with or	XXX	0.52	XXX	5			15	5	25	RUC	2017-04	UROLOGY	0.0197		166220
93272	External patient and, when per	XXX	0.52		5			15	10	30	RUC		CARDIOLOGY	0.0123		104829
92570	Acoustic immittance testing, in	XXX	0.55	XXX	3			15	3	21	RUC	2009-04	AUDIOLOGIST (IND.)	0.0277		38849
76881	Ultrasound, complete joint (ie,	XXX	0.63	XXX	5			15	5	25	RUC	2010-04	RHEUMATOLOGY	0.0271		196753
99241	Office consultation for a new o	XXX	0.64		5			15	5	25	RUC	2006-02		0.0277		
62368	Electronic analysis of programn	XXX	0.67		7			15	5	27	RUC	2011-02	ANESTHESIOLOGY	0.0267		43410
62369	Electronic analysis of programn	XXX	0.67	XXX	7			15	5	27	RUC	2011-02	INTERVENTIONAL PAI	0.0267		31581
76942	Ultrasonic guidance for needle	XXX	0.67	XXX	7			15	5	27	RUC	2014-04	ANESTHESIOLOGY	0.0267		1178266
99447	Interprofessional telephone/In	XXX	0.70	XXX	3			15	5	23	RUC	2012-10	EMERGENCY MEDICIN	0.0347		5600
93970	Duplex scan of extremity veins	XXX	0.70		3			15	5	23	RUC	2014-04	DIAGNOSTIC RADIOLO	0.0347		1626806
76510	Ophthalmic ultrasound, diagno	XXX	0.70	XXX	3			15	2	20	RUC	2016-10	OPHTHALMOLOGY	0.0392		14435
95251	Ambulatory continuous glucose	XXX	0.70	XXX	2			15	3	20	RUC	2016-10	ENDOCRINOLOGY	0.0392	Yes	248288
99451	Interprofessional telephone/In	XXX	0.70	XXX				15	8	23	RUC	2018-01	CARDIOLOGY	0.0347		6188
93880	Duplex scan of extracranial arte	XXX	0.80	XXX	5			15	5	25	RUC	2014-04	DIAGNOSTIC RADIOLO	0.0384		2198611
93925	Duplex scan of lower extremity	XXX	0.80	XXX	5			15	5	25	RUC	2014-04	DIAGNOSTIC RADIOLO	0.0384		661535
93930	Duplex scan of upper extremity	XXX	0.80	XXX	5			15	5	25	RUC	2014-04	DIAGNOSTIC RADIOLO	0.0384		23417
93976	Duplex scan of arterial inflow a	XXX	0.80	XXX	5			15	5	25	RUC	2014-04	DIAGNOSTIC RADIOLO	0.0384		173269
93978	Duplex scan of aorta, inferior v	XXX	0.80	XXX	5			15	5	25	RUC	2014-04	VASCULAR SURGERY	0.0384		287616
74250	Radiologic examination, small i	XXX	0.81	XXX	3			15	5	23	RUC	2018-10	DIAGNOSTIC RADIOLO	0.0421		52021
72265	Myelography, lumbosacral, rad	XXX	0.83	XXX	5			15	5	25	RUC	2014-04	DIAGNOSTIC RADIOLO	0.0404		3681
92002	Ophthalmological services: med	XXX	0.88		5			15	5	25	RUC	2007-02	OPHTHALMOLOGY	0.0437	Yes	211631
78227	Hepatobiliary system imaging, i	XXX	0.90	XXX	6			15	5	26	RUC	2011-02	DIAGNOSTIC RADIOLO	0.0436		64389
95923	Testing of autonomic nervous s	XXX	0.90	XXX	5			15	10	30	RUC	2012-04	INTERNAL MEDICINE	0.0376		114086
74246	Radiologic examination, upper	XXX	0.90	XXX	4			15	3	22	RUC	2019-01	DIAGNOSTIC RADIOLO	0.0495		34438
72255	Myelography, thoracic, radiolog	XXX	0.91	XXX	5			15	5	25	RUC	2014-04	DIAGNOSTIC RADIOLO	0.0457		125
95983	Electronic analysis of implanted	XXX	0.91	XXX	3			15	10	28	RUC	2017-10	NEUROLOGY	0.0413		40522
92012	Ophthalmological services: med	XXX	0.92		5			15	5	25	RUC	2007-02	OPHTHALMOLOGY	0.0464	Yes	6617899
78265	Gastric emptying imaging study	XXX	0.98	XXX	5			15	5	25	RUC	2015-04	DIAGNOSTIC RADIOLO	0.0504		1303
78278	Acute gastrointestinal blood lo	XXX	0.99	XXX	5			15	10	30	RUC	2011-09	DIAGNOSTIC RADIOLO	0.0436		26257
73200	Computed tomography, upper	XXX	1.00		5			15	5	25	RUC	2009-10	DIAGNOSTIC RADIOLO	0.0517		126320
91111	Gastrointestinal tract imaging,	XXX	1.00		5			15	5	25				0.052		146
74270	Radiologic examination, colon,	XXX	1.04	XXX	4			15	5	24	RUC	2018-10	DIAGNOSTIC RADIOLO	0.0559		28934
99334	Domiciliary or rest home visit fo	XXX	1.07		5			15	10	30	RUC	2007-02	PODIATRY	0.0489		500533
95816	Electroencephalogram (EEG); in	XXX	1.08	XXX	5			15	6	26	RUC	2012-10	NEUROLOGY	0.0556		278212
95819	Electroencephalogram (EEG); in	XXX	1.08	XXX	5			15	6	26	RUC	2012-10	NEUROLOGY	0.0556	Yes	202028
95812	Electroencephalogram (EEG) ex	XXX	1.08	XXX	5			15	5	25	RUC	2016-01	NEUROLOGY	0.0571		24822
76391	Magnetic resonance (eg, vibrati	XXX	1.10	XXX	5			15	5	25	RUC	2018-01	DIAGNOSTIC RADIOLO	0.0584		2452
71250	Computed tomography, thorax	XXX	1.16	XXX	5			15	5	25	RUC	2016-04	DIAGNOSTIC RADIOLO	0.0624		2320224
78071	Parathyroid planar imaging (inc	XXX	1.20	XXX	5			15	5	25	RUC	2012-04	DIAGNOSTIC RADIOLO	0.0651		8974
72126	Computed tomography, cervica	XXX	1.22	XXX	5			15	5	25	RUC	2018-04	DIAGNOSTIC RADIOLO	0.0664		20553
72129	Computed tomography, thorac	XXX	1.22	XXX	5			15	5	25	RUC	2018-04	DIAGNOSTIC RADIOLO	0.0664		26437
70470	Computed tomography, head o	XXX	1.27	XXX	5			15	5	25	RUC	2011-04	DIAGNOSTIC RADIOLO	0.0697		92135
70488	Computed tomography, maxillo	XXX	1.27	XXX	5			15	5	25	RUC	2014-04	DIAGNOSTIC RADIOLO	0.0697		3505
70482	Computed tomography, orbit, s	XXX	1.27	XXX	4			15	4	23	RUC	2018-10	DIAGNOSTIC RADIOLO	0.0727		4917
70490	Computed tomography, soft tis	XXX	1.28	XXX	5			15	5	25	RUC	2017-01	DIAGNOSTIC RADIOLO	0.0704		68230
70480	Computed tomography, orbit, s	XXX	1.28	XXX	4			15	3	22	RUC	2018-10	DIAGNOSTIC RADIOLO	0.0749		54791
78454	Myocardial perfusion imaging,	XXX	1.34	XXX	5			15	5	25	RUC	2009-02	DIAGNOSTIC RADIOLO	0.0744		10009
73718	Magnetic resonance (eg, proton	XXX	1.35	XXX	5			15	5	25	RUC	2016-10	DIAGNOSTIC RADIOLO	0.0751		148143
99283	Emergency department visit for	XXX	1.42	XXX	5			15	10	30	RUC	2018-04	EMERGENCY MEDICIN	0.0723	Yes	2744710
93350	Echocardiography, transthoraci	XXX	1.46	XXX	5			15	10	30	RUC	2016-10	CARDIOLOGY	0.0749		95788
70546	Magnetic resonance angiograph	XXX	1.48	XXX	5			15	5	25	RUC	2016-10	DIAGNOSTIC RADIOLO	0.0837		18220
70548	Magnetic resonance angiograph	XXX	1.50	XXX	5			15	5	25	RUC	2016-10	DIAGNOSTIC RADIOLO	0.0851		17524
78491	Myocardial imaging, positron e	XXX	1.56	XXX	8			15	7	30	RUC	2019-01	CARDIOLOGY	0.0816		1809

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 91111

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 438
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2019 volume (146) * 3 = 438

Specialty Gastroenterology Frequency 386 Percentage 88.12 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 146
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2019 volume = 146

Specialty Gastroenterology Frequency 129 Percentage 88.35 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Tests

BETOS Sub-classification:
Other tests

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 91111

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:91113 Tracking Number Original Specialty Recommended RVU: **2.41**
Presented Recommended RVU: **2.48**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **2.41**

CPT Descriptor: Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year old female who is referred for a diagnostic optical colonoscopy. The patient completes an effective bowel preparation regimen but due to angulation and fixation of colonic loops or difficult colonic anatomy, colonoscopy is not able to be completed. The patient is referred for colon capsule endoscopy to complete visualization of the colon.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The patient is assessed for possible contraindications such as presence of pacemaker, active bowel obstruction, or swallowing disorder. The patient is educated about the nature of the procedure, why it is being performed, and possible complications. Patient is instructed on how to prepare for the procedure (eg, fasting and wearing the proper clothing) as well as the complicated nature of the preparation which involves portions to be taken at home and portions to be taken upon arrival at the clinical site.

Description of Intra-Service Work: The physician reviews the images with the localization software activated to input the esophagogastric junction, pylorus, and ileocecal valve locations. The physician scans the study and keys annotated anatomic landmarks (eg, esophagogastric junction, first gastric image, first duodenal image, ileocecal valve, first cecal image, hepatic flexure, splenic flexure, and last rectal image), permitting identification of potentially positive findings and determination of gastric, small bowel and colonic transit times. Once the landmarks are determined, all images are then viewed with the two different capsule cameras (front and back). This is in effect reviewing two capsule studies, one from the forward view camera and one from the trailing view camera. When the physician identifies an abnormality it is measured and a thumbnail is created. Key findings or abnormalities are noted. Images or abnormalities noted on the two different viewing cameras must be carefully analyzed and reconciled to determine if they represent two distinct pathologies or the same pathology from two different vantage points. This is critically important to avoid false positive findings. Localization is determined by passage of time or by capsule localization software.

Description of Post-Service Work: After all images are reviewed and an interpretation is formulated, the physician prepares a report. The findings are communicated to the patient and a copy of the report is sent to the referring physician. The referring physician may also be contacted to discuss the findings.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021
Presenter(s):	R. Bruce Cameron, MD, ACG Shivan Mehta, MD, AGA Patricia Garcia, MD, AGA Seth A. Gross, MD, ASGE Vivek Kaul, MD, ASGE
Specialty Society(ies):	American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy
CPT Code:	91113
Sample Size:	3416 **Resp N:** 58
Description of Sample:	With permission from the Research Subcommittee we conducted a targeted survey using data from the vendor on physicians who have performed colon capsule endoscopy. Originally, we understood the list would contain contact information for 520 physicians; however, the list we recived contained 449 physicians. We also conducted a random sample of 3000 of our societies' memberships; however, once the list was cross-checked with the email address in the industry list for duplicates and bad email addresses had been removed, the random sample was 2,967.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	4.00	30.00
Survey RVW:	1.40	2.41	**2.58**	3.44	10.00
Pre-Service Evaluation Time:			**11.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	91113	**Recommended Physician Work RVU: 2.48**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)
XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74262	XXX	2.50	**RUC Time**

CPT Descriptor Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99235	XXX	3.24	**RUC Time**

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99326	XXX	2.63	**RUC Time**	57,317

CPT Descriptor 1 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are

provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
75635	XXX	2.40	**RUC Time**	114,472

CPT Descriptor 2 Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 22 **% of respondents:** 37.9 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 24.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 91113	**Top Key Reference CPT Code:** 74262	**2nd Key Reference CPT Code:** **99235**
Median Pre-Service Time	5.00	5.00	14.00
Median Intra-Service Time	45.00	45.00	50.00
Median Immediate Post-service Time	10.00	7.00	19.50
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**57.00**	**83.50**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**

Overall intensity/complexity	0%	4%	35%	39%	22%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	30%	61%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	44%	56%
Physical effort required	0%	48%	52%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	39%	57%

2nd Key Reference Code

	Much Less	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	7%	40%	13%	40%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	27%	53%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	47%	53%
Physical effort required	27%	40%	33%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel accepted a proposal from industry (Medtronic) presented at the October 2020 CPT Editorial Panel meeting to convert Category III code 0355T for colon capsule endoscopy to Category I. Colon capsule endoscopy is related to two other Category I CPT codes, capsule endoscopy of the small bowel (91110) and the esophagus (91111), which were last reviewed together by the RUC in January 2016. Codes 91110 and 91111 were surveyed with new CPT code 91113 by the ACG, AGA and ASGE.

The Research Subcommittee approved our proposed survey methodology to use both a targeted survey and random sample due to low performance cited by the applicant in the CPT application for colon capsule endoscopy (91113). The Research Subcommittee also provided input on our reference service list.

The ACG, AGA, and ASGE conducted a survey of existing CPT codes 91110 and 91111 and new CPT code 91113 for presentation at the January 2021 RUC meeting.

91110 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report

91111 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report

91113 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report

Our multi-specialty consensus panel reviewed the survey data for codes 91110, 91111 and 91113, comparing the data and work RVUs (wRVUs) to the current data for similar XXX-day global codes that were recently approved by the RUC.

NOTE: Highlighted language below has been updated from the original SOR submission.

91113 – Discussion and Recommendation

Code 91113 is a new CPT code approved at the October 2020 CPT Editorial Panel meeting to convert Category III code 0355T for colon capsule endoscopy to Category I. The ACG, AGA, and ASGE conducted a survey for the January 2021 RUC meeting and received 58 responses (40 from the random sample and 18 from the targeted survey of the industry list). Because the median experience for 91113 was 0, we provided a data breakdown in the Survey Summary Spreadsheet on those who reported performing the procedure in the past 12 months vs those who did not. Additionally, the Pre-facilitation committee advised us to provide the data breakdown for those who had performed the procedure in the past 5 years since the number of those who performed the procedure in the past 12 months did not meet the RUC's minimum survey response. There are 35 participants who reported performing 91113 in the past 5 years.

ISSUE: Capsule endoscopy
TAB: 21

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	74262	XXX	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	22	0.050	0.044			2.50			57	5					45			7					
2nd REF	99235	XXX	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which	14	0.050	0.039			3.24			83.5	14					50			19.5					
CURRENT					#DIV/0!	#DIV/0!						0														
SVY	9111X	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	58	0.047	0.039	1.40	2.41	2.58	3.44	10.00	66	11			10	30	45	60	120	10	0	0	0	4	30
Targeted	9111X	XXX	Gastrointestinal tract imaging,	18	0.049	0.038	2.00	2.50	2.95	3.84	5.50	78	15			20	33	45	58	90	18	0	0	2	6	25
Random	9111X	XXX	Gastrointestinal tract imaging,	40	0.047	0.039	1.40	2.30	2.56	3.20	10.00	65	10			10	28	45	60	120	10	0	0	0	2	30
No exp - 12 mos	9111X	XXX	Gastrointestinal tract imaging,	29	0.047	0.039	1.50	2.48	2.56	3.03	5.00	65	10			10	29	45	60	90	10	0	0	0	0	0
Exp - 12 mos	9111X	XXX	Gastrointestinal tract imaging,	29	0.046	0.037	1.40	2.45	2.75	3.50	10.00	75	15			15	35	45	60	120	15	1	2	4	6	30
Exp - 12 mos to 5 yrs	9111X	XXX	Gastrointestinal tract imaging,	35	0.046	0.037	1.40	2.48	2.69	3.50	10.00	72	15			10	30	45	60	120	12	1	2	5	9	100
REC	9111X	XXX	Gastrointestinal tract imaging, intral		0.048	0.041			2.48			60	5					45			10					

We recommend a **wRVU of 2.48**. This value is equal to the 25th percentile of the survey data of the survey participants who reported having performed the procedure in the past 5 years.

Pre-time Package XXX is appropriate with 5 minutes of evaluation time, consistent with other capsule endoscopy codes 91110 and 91111.

Pre-service evaluation time: 5 minutes
Pre-service positioning time: 0 minutes
Pre-service scrub, dress, wait time: 0 minutes

Post-time Package XXX is appropriate with of 10 minutes of immediate post-service time, reflecting the survey median.

Intra-service time of 45 minutes is appropriate, reflecting the survey median.

Key Reference Services
Two reference services were selected more often than others: 74262 and 99235. However, code 74262 (*Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed*) was selected most often (22/58).

Comparison to other recently RUC-reviewed codes with 45 minutes intra-service time:

CPT Code	Long Desc	Glob	Work RVU	Pre Time Pkg	Pre Eval Time	Pre Position Time	Pre Scrub, Dress, Wait Time	Intra Time	Imm Post Time	Total Time	Time Source	Most Recent RUC Review	Top_Specialty	IWPUT	MPC	2019 Medicare Util
38208	Transplant preparation of h	XXX	0.56		5			45	10	60	RUC	2002-09		0.005		
92526	Treatment of swallowing dy	XXX	1.34	XXX	5			45	5	55	RUC	2009-02	SPEECH LANGUAGE PATH	0.0248		133424
77770	Remote afterloading high d	XXX	1.95	XXX	6			45	10	61	RUC	2015-01	RADIATION ONCOLOGY	0.0354		17117
92072	Fitting of contact lens for m	XXX	1.97	XXX	10			45	10	65	RUC	2011-04	OPTOMETRY	0.0338		2385
90834	Psychotherapy, 45 minutes	XXX	2.00	XXX	5			45	10	60	RUC	2012-04	LICENSED CLINICAL SOCIA	0.037		4939452
9111X	Gastrointestinal tract imagi	XXX	2.48	XXX	5			45	10	60				0.048		
74262	Computed tomographic (CT	XXX	2.50	XXX	5			45	7	57	RUC	2009-04	DIAGNOSTIC RADIOLOGY	0.0496		624
70555	Magnetic resonance imagin	XXX	2.54		10			45	10	65	RUC	2006-02	DIAGNOSTIC RADIOLOGY	0.0465		317
75561	Cardiac magnetic resonanc	XXX	2.60		10			45	10	65	RUC	2007-04	DIAGNOSTIC RADIOLOGY	0.0478		29956

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0355T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 316
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. According to the company's Category I CPT application for colon capsule endoscopy, "From June 2017 - June 2018, 316 colon capsule endoscopy procedures have been documented as completed."

Specialty Gastroenterology Frequency 316 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 105
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate one third of the volume will be provided to Medicare patients.

Specialty Gastroenterology Frequency 105 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Tests

BETOS Sub-classification:
Other tests

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 91110

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Capsule endoscopy
TAB: 21

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	74262	XXX	Computed tomography, (CT) colonography, diagnostic, including image postprocessing; with	28	0.050	0.044			2.50			57	5					45			7					
2nd REF	91112	XXX	Gastrointestinal transit and pressure measurement, stomach through colon, wireless	25	0.041	0.035			2.10			60	5					40			15					
CURRENT	91110	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum,		0.045	0.038			2.49			65	5					45			15					
SVY	91110	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum,	104	0.053	0.043	1.08	2.24	2.56	3.20	10.00	60	10			3	30	40	60	120	10	0	12	30	51	1225
Targeted	91110	XXX	Gastrointestinal tract imaging, intraluminal (eg,	25	0.067	0.046	1.08	2.15	2.60	3.50	6.00	56.5	14			10	21	30	40	90	12.5	5	23	50	84	321
Random	91110	XXX	Gastrointestinal tract imaging, intraluminal (eg,	79	0.048	0.040	1.10	2.26	2.56	3.00	10.00	63.5	10			3	30	44	60	120	10	0	10	23	50	1225
REC	91110	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum,		0.048	0.041			2.24			55	5					40			10					

1st REF	91112	XXX	Gastrointestinal transit and pressure measurement, stomach through colon, wireless	9	0.041	0.035			2.10			60	5					40			15					
2nd REF	74250	XXX	Radiologic examination, small intestine, including multiple serial images and scout	8	0.042	0.035			0.81			23	3					15			5					
CURRENT	91111	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with		0.043	0.036			1.00			28	5					18			5					
SVY	91111	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with	56	0.103	0.057	0.75	1.11	2.00	2.50	10.00	35	10			5	10	15	28	75	10	0	0	0	3	40
Targeted	91111	XXX	Gastrointestinal tract imaging, intraluminal (eg,	17	0.105	0.050	0.80	0.92	1.50	2.50	4.00	30	10			3	7	10	15	60	10	0	0	0	2	20
Random	91111	XXX	Gastrointestinal tract imaging, intraluminal (eg,	39	0.103	0.057	0.75	1.20	2.00	2.50	10.00	35	10			5	10	15	30	75	10	0	0	0	3	40
No exp 12	91111	XXX	Gastrointestinal tract imaging, intraluminal (eg,	29	0.070	0.043	0.80	1.00	1.50	2.10	2.56	35	10			5	10	15	25	75	10	0	0	0	0	0
Exp 12 mos	91111	XXX	Gastrointestinal tract imaging, intraluminal (eg,	27	0.115	0.056	0.75	1.39	2.30	2.79	10.00	41	11			10	13	15	31	60	15	1	2	5	10	40
REC	91111	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report		0.052	0.040			1.00			25	5					15			5					

1st REF	74262	XXX	Computed tomography, (CT) colonography, diagnostic, including image postprocessing; with	22	0.050	0.044			2.50			57	5					45			7					
2nd REF	99235	XXX	Observation or inpatient hospital care, for the evaluation and management of a patient	14	0.050	0.039			3.24			83.5	14					50			19.5					
CURRENT																										
SVY	91113	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation	58	0.047	0.039	1.40	2.41	2.58	3.44	10.00	66	11			10	30	45	60	120	10	0	0	0	4	30
Targeted	91113	XXX	Gastrointestinal tract imaging, intraluminal (eg,	18	0.049	0.038	2.00	2.50	2.95	3.84	5.50	78	15			20	33	45	58	90	18	0	0	2	6	25
Random	91113	XXX	Gastrointestinal tract imaging, intraluminal (eg,	40	0.047	0.039	1.40	2.30	2.56	3.20	10.00	65	10			10	28	45	60	120	10	0	0	0	2	30
No exp 12	91113	XXX	Gastrointestinal tract imaging, intraluminal (eg,	29	0.047	0.039	1.50	2.48	2.56	3.03	5.00	65	10			10	29	45	60	90	10	0	0	0	0	0
Exp 12 mos	91113	XXX	Gastrointestinal tract imaging, intraluminal (eg,	29	0.046	0.037	1.40	2.45	2.75	3.50	10.00	75	15			15	35	45	60	120	15	1	2	4	6	30
Exp 12 mos to 5 yrs	91113	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation	35	0.046	0.037	1.40	2.48	2.69	3.50	10.00	72	15			10	30	45	60	120	12	1	2	5	9	100
REC	91113	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report		0.046	0.040			2.41			60	5					45			10					

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 91110, 91111, 91113

SPECIALTY SOCIETY(IES): ACG, AGA, ASGE

PRESENTER(S): R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	XXX
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	XXX
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
91110	A 70-year-old patient with recurrent, obscure gastrointestinal bleeding not diagnosed by other imaging and endoscopic procedures is referred for evaluation. Wireless capsule endoscopy is performed.
91111	A 65-year-old patient with cirrhosis and compromised liver function is referred for screening for esophageal varices. Wireless capsule endoscopy is performed.
91113	A 60-year old female who is referred for a diagnostic optical colonoscopy. The patient completes an effective bowel preparation regimen but due to angulation and fixation of colonic loops or difficult colonic anatomy, colonoscopy is not able to be completed. The patient is referred for colon capsule endoscopy to complete visualization of the colon.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The ACG, AGA and ASGE convened an RVS expert panel of the surveying specialty societies to review practice expense data for codes 91110, 91111 and 91113. The panel included both sub-specialists and generalists from within the specialties of a variety of settings across the United States. They also received input from practice managers and clinical staff familiar with the direct expense inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Current CPT codes 91110 and 91111 were compared to their current PE inputs. New CPT code 91113 was compared to 91110.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Codes 91110 and 91111 are not typically reported with an E/M. Code 91113 is a new code, but we do not expect it will typically be reported with an E/M.

Code 91110 is billed together with an office E/M code 2.6% of the time.
Code 91111 is billed together with an office E/M code 0% of the time.
Code 91113 is a new code with no billed together data yet.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Gastroenterology is the dominant specialty for code 91110 in the nonfacilty, reporting it 93.1% of the time. The dominant provider in the nonfacility, gastroenterology, is the same as for the global.

Gastroenterology is the dominant specialty for code 91111 in the nonfacility, reporting it 83.3% of the time. The dominant provider in the nonfacility, gastroenterology, is the same as for the global.

Code 91113 is a new code and has no data yet, but we expect gastroenterology will be the dominant specialty in the nonfacility and the same for the global.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

91110 Pre-Service Clinical Labor Activities = RN/LPN/MTA
No time above the PE Subcommittee standards for clinical activities is being requested

91110 Intra-Service Clinical Labor Activities = RN/LPN/MTA

- 3 minutes to provide education and consent activities, including what to expect during the procedure, what to do (and avoid doing) after leaving the office (e.g., every 15 minutes verify the Data Recorder lights is blinking twice per second, after eight hours or when you see the camera capsule in the toilet after a bowel movement, whichever comes first, remove the patches and the recorder from your body, pack them in a bag and follow your doctor's instructions for returning the equipment). For an example of educational instructions, see the Mayo Clinic's Patient Care and Instructions for small bowel capsule endoscopy https://www.mayoclinic.org/tests-procedures/capsule-endoscopy/about/pac-20393366 (CA011)
- 10 minutes to prepare room, equipment, data recorder, sensors, and workstation (CA013)
- 6 minutes to connect the equipment, fit belt to patient, put data recorder on patient, sync capsule to each sensor on belt (CA016)
- 4 minutes to assist patient with capsule ingestion and observe patient to ensure no complications (e.g., not in airway, Zenker's diverticulum, caught in esophageal stricture) (CA021)
- 6 minutes to disconnect belt, recorder, and sensor array and clean room and equipment (CA024)
- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

NONFACILITY DIRECT PE INPUTS
CPT CODE(S): 91110, 91111, 91113
SPECIALTY SOCIETY(IES): ACG, AGA, ASGE
PRESENTER(S): R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

91110 Post-Service Clinical Labor Activities = RN/LPN/MTA
Note that the RUC database reflects the CMS files which have CA032 in the post-service period for the capsule endoscopy codes 91110 and 91111 rather than the post-service of the service period.

91111 Pre-Service Clinical Labor Activities = RN/LPN/MTA
No time above the PE Subcommittee standards for clinical activities is being requested

91111 Intra-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to provide education and consent activities (CA011)
- 10 minutes to prepare room, equipment, data recorder, sensors, and workstation (CA013)
- 9 minutes to prepare and position patient (CA016)
    - 6 minutes to connect the equipment, fit belt, put data recorder on patient, sync capsule to each sensor
    - 3 minutes to position patient (assist patient onto table lying down on right side and then into a sitting position after the capsule is swallowed)
- 8 minutes to give patient 100c water to drink (1 min), observe swallow capsule and take one sip every 30 seconds (7 min), assist patient to sit upright and take another sip of water and wait 30 seconds (CA021)
- 6 minutes to disconnect belt, recorder, and sensor array and clean room and equipment (CA024)
- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

91111 Post-Service Clinical Labor Activities = RN/LPN/MTA
Note that the RUC database reflects the CMS files which have CA032 in the post-service period for the capsule endoscopy codes 91110 and 91111 rather than the post-service of the service period.

91113 Pre-Service Clinical Labor Activities = RN/LPN/MTA
No time above the PE Subcommittee standards for clinical activities is being requested

91113 Intra-Service Clinical Labor Activities = RN/LPN/MTA
- 9 minutes to provide education and consent activities. See Attachment A (GCC PillCam Colon Packet- post ingestion instructions) for an example of educational instruction.
    - 1 minute to obtain consent
    - 5 minutes to provide education to understand prompts on digital recorder and what to do
    - 3 minutes to go over on-site bowel preparation
- 10 minutes to prepare room, equipment, data recorder, sensors, and workstation (CA013)
- 6 minutes to prepare and position patient, including connect the equipment, fit belt to patient, put data recorder on patient, sync capsule to each sensor on belt (CA016)
- 10 minutes to assist patient with capsule ingestion, observe patient to ensure no complication, and observe patient over 60 minutes post ingestion (CA021)
    - 2 minutes to assist patient with capsule ingestion

  - 2 minutes to observe patient immediately following ingestion to ensure no complications
  - 6 minutes to check on the patient at 10-minute intervals over a 60-minute period post-ingestion (1-minute check-in every 10 minutes over 60 minutes = 6 minutes)
    - Staff spend 1 minute with the patient during each of the 6 check-ins reviewing recorder prompts and using the real-time reader to localize the capsule location to confirm that the capsule exits the stomach.
- 6 minutes to disconnect belt, recorder, and sensor array and clean room and equipment (CA024)
- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

91113 Post-Service Clinical Labor Activities = RN/LPN/MTA
No time is being requested.

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

91111
The capsule download time for the recording for ES029 was unintentionally omitted from 91111 and we ask the RUC to add it which will increase the aggregate current cost for equipment. The recording time for 91111 is 30 minutes.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 91110, 91111, 91113

SPECIALTY SOCIETY(IES): ACG, AGA, ASGE

PRESENTER(S): R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

*Please note: If a supply has a purchase price of $100 or more please bold the item name and CMS code.			91110 Proposed Inputs		91111 Prop Inputs	
Meeting Date: January 2016 Tab: 44 Specialty: ACG, AGA, ASGE	CMS Code	Staff Type	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report		Gastrointestina imaging, intralu (eg, capsu endoscopy esophagus v interpretation report	
LOCATION			Non Fac	Facility	Non Fac	Fa
GLOBAL PERIOD: XXX						
Other Clinical Activity: observe patient to ensure no complications (not in airway, zinker's diverticulum or caught in esophageal stricture)	L037D	RN/LPN/MTA	2			
Other Clinical Activity: position patient (assist patient onto table lying down on right side and then into a sitting position after the capsule is swallowed)					3	
Other Clinical Activity: Give pt 100c water to drink (1 min), observe swallow pillcam and take one sip every 30 seconds (7 min), assist patient to sit upright and take another sip of water and wait 30 seconds					8	
Post-Service						
Monitor pt. following moderate sedation						
Other clinical activity: disconnect belt, recorder and sensor array			3		3	
POST-SERVICE Period						
Start: Patient leaves office/facility						
Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA				
Other Clinical Activity: *recharge batteries, initiate data download to workstation, create image archive*	L037D	RN/LPN/MTA	4		4	

Other Clinical Activity: observe patient to ensure no complications (not in airway, Zenker's diverticulum or caught in esophageal stricture) was rolled into CA021 as part of the clinical staff's performance of the procedure.

Other Clinical Activity: position patient (assist patient onto table lying down on right side and then into a sitting position after the capsule is swallowed) was rolled into CA016 as part of prepare and positioning patient activity.

Other Clinical Activity: disconnect belt, recorder and sensor array was rolled into CA024 as part of cleaning the equipment.

Other Clinical Activity: recharge batteries, initiate data download to workstation, create image archive was rolled into CA032. Note that the RUC database reflects the CMS files that has the CA032 in the post-service period for these codes rather than the post-service of the service period.

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

CA010 for 91110 and 91111 was 3 minutes prior to CMS increasing clinical activity to 5 minutes for calendar year 2018.

For codes 91110, 91111 and 91113, at least 4 vital signs are taken prior to beginning the procedure to ensure the patient is healthy enough to undergo the capsule endoscopy procedure. Vital signs taken prior to the procedure include patient's temperature, heart rate, respiratory rate, and blood pressure and may include additional vital signs.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

91110, 91111 and 91113 Pre-Service Clinical Labor Activities = RN/LPN/MTA
- 5 minutes to complete pre-service diagnostic & referral forms (CA001)
- 3 minutes to provide follow-up phone calls & prescriptions (CA005)

   b. Service period (includes pre, intra and post):

91110 Intra-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to provide education and consent activities (CA011)
- 10 minutes to prepare room, equipment and supplies (CA013)
- 6 minutes to prepare and position patient (CA016)
- 4 minutes to perform procedure/service not related to physician work (CA021)
- 6 minutes to clean room/equipment (CA024)
- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

91111 Intra-Service Clinical Labor Activities = RN/LPN/MTA
- 3 minutes to provide education and consent activities (CA011)
- 10 minutes to prepare room, equipment, supplies (CA013)
- 9 minutes to prepare and position patient (CA016)
- 8 minutes to perform procedure/service not related to physician work time (CA021)
- 6 minutes to clean room/equipment (CA024)
- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

91113 Intra-Service Clinical Labor Activities = RN/LPN/MTA
- 9 minutes to provide education and consent activities
- 10 minutes to prepare room, equipment, supplies (CA013)
- 6 minutes to prepare and position patient (CA016)
- 10 minutes to perform procedure/service not related to physician work time (CA021)
- 6 minutes to clean room/equipment (CA024)
- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

   c. Post-service period:

91110, 91111 and 91113 Post-Service Clinical Labor Activities = RN/LPN/MTA

NONFACILITY DIRECT PE INPUTS
CPT CODE(S): 91110, 91111, 91113
SPECIALTY SOCIETY(IES): ACG, AGA, ASGE
PRESENTER(S): R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Note that the RUC database reflects the CMS files that has the CA032 in the post-service period for these codes rather than the post-service of the service period.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

91110 Intra-Service Clinical Labor Activities = RN/LPN/MTA

- 3 minutes to provide education and consent activities, including what to expect during the procedure, what to do (and avoid doing) after leaving the office (e.g., every 15 minutes verify the Data Recorder lights is blinking twice per second; after eight hours or when you see the camera capsule in the toilet after a bowel movement, whichever comes first, remove the patches and the recorder from your body, pack them in a bag and follow your doctor's instructions for returning the equipment). For an example of educational instructions, see the Mayo Clinic's Patient Care and Instructions for small bowel capsule endoscopy https://www.mayoclinic.org/tests-procedures/capsule-endoscopy/about/pac-20393366 (CA011)
- 10 minutes to prepare room, equipment, data recorder, sensors, and workstation (CA013)
- 6 minutes to connect the equipment, fit belt to patient, put data recorder on patient, sync capsule to each sensor on belt (CA016)
- 4 minutes to assist patient with capsule ingestion and observe patient to ensure no complications (CA021)
- 6 minutes to disconnect belt, recorder, and sensor array and clean room and equipment (CA024)
- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

91111 Intra-Service Clinical Labor Activities = RN/LPN/MTA

- 3 minutes to provide education and consent activities (CA011)
- 10 minutes to prepare room, equipment, data recorder, sensors, and workstation (CA013)
- 9 minutes to prepare and position patient (CA016)
    - 6 minutes to connect the equipment, fit belt, put data recorder on patient, sync capsule to each sensor
    - 3 minutes to position patient (assist patient onto table lying down on right side and then into a sitting position after the capsule is swallowed)
- 8 minutes to give patient 100c water to drink (1 min), observe swallow capsule and take one sip every 30 seconds (7 min), assist patient to sit upright and take another sip of water and wait 30 seconds (CA021)
- 6 minutes to disconnect belt, recorder, and sensor array and clean room and equipment (CA024)

- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

91113 Intra-Service Clinical Labor Activities = RN/LPN/MTA

- 9 minutes to provide education and consent activities. See Attachment A (GCC PillCam Colon Packet- post ingestion instructions) for an example of educational instruction.
    - 1 minute to obtain consent
    - 5 minutes to provide education to understand prompts on digital recorder
    - 3 minutes to go over on-site bowel preparation
- 10 minutes to prepare room, equipment, data recorder, sensors, and workstation (CA013)
- 6 minutes to prepare and position patient, including connect the equipment, fit belt to patient, put data recorder on patient, sync capsule to each sensor on belt (CA016)
- 10 minutes to assist patient with capsule ingestion, observe patient to ensure no complication, and observe patient over 60 minutes post ingestion (CA021)
    - 2 minutes to assist patient with capsule ingestion
    - 2 minutes to observe patient immediately following ingestion to ensure no complications
    - 6 minutes to check on the patient at 10-minute intervals over a 60-minute period post-ingestion (1-minute check-in every 10 minutes over 60 minutes = 6 minutes)
        - Staff spend 1 minute with the patient during each of the 6 check-ins reviewing recorder prompts and using the real-time reader to localize the capsule location to confirm that the capsule exits the stomach.
- 6 minutes to disconnect belt, recorder, and sensor array and clean room and equipment (CA024)
- 4 minutes to recharge batteries, initiate data download to workstation and create image archive (CA032)

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

Not applicable. Staff work time is independent and separate from physician work time.

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

Not applicable

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

Not applicable

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

Code 91113 requires a colon capsule. Invoices for the PillCam® COLON 2 capsule accompany the submission for Tab 21. Please see the "Tab 21 – invoice summary" Excel document.

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

Pack, minimum multi-specialty visit - SA048; unit price = $4.05 - paper, exam table = 7 feet - gloves, non-sterile = 2 pair - gown, patient = 1 item - pillowcase = 1 item - cover, thermometer probe = 1 item

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

Not applicable

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

Not applicable

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF023 – exam table = Default EQ146 – kit, capsule endoscopy recorder = Other Formula ES029 – video system, capsule endoscopy (software, computer, monitor, printer) = Other Formula **91110 Equipment Formula for EQ146 (capsule endoscopy recorder kit)**

The equipment formula approved by the RUC at the January 2016 RUC meeting (tab 44) for EQ146 included 10 minutes to prepare the room, equipment and supplies, 6 minutes to position to the patient connect the equipment, apply sensor array, fit belt, put data recorder on patient, sync capsule to each sensor, 2 minutes to observe capsule ingestion to ensure no complications, and 3 minutes to disconnect the belt, recorder and sensor array plus 480 minutes recording time for the capsule endoscopy and 80 minutes for the images to download to the computer and be processed by the software.

The equipment formula we are currently submitting for approval is:
CA013 + CA016 + 480 minutes recording time of the small bowel capsule + 80 minutes for the images to download to the computer and be processed by the software

The formula above reflects the time the capsule is in use during the preparation of equipment and supplies (CA013), during preparation of the patient when the capsule is synced to each sensor on the belt and the equipment is connected (CA016), the time the capsule is recording post-ingestion and the time for image download and processing.

91111 Equipment Formula for EQ146 (capsule endoscopy recorder kit)
The equipment formula approved by the RUC at the January 2016 RUC meeting (tab 44) for EQ146 included 10 minutes to prepare the room, equipment and supplies, 6 minutes to position to the patient connect the equipment, apply sensor array, fit belt, put data recorder on patient, sync capsule to each sensor and 3 minutes to disconnect the belt, recorder and sensor array plus 15 minutes for images to download to the computer. **However, the 30 minutes of recording time for the capsule is missing and we ask the RUC to include it in our current submission**.

The equipment formula we are currently submitting for approval is:
CA013 + CA016 + 30 minutes of recording time for the esophagus capsule + 15 minutes for the images to download to the computer and be processed by the software.

The formula above reflects the time the capsule is in use during the preparation of equipment and supplies (CA013), during preparation of the patient when the capsule is synced to each sensor on the belt and the equipment is connected (CA016), the time the capsule is recording post-ingestion and the time for image download and processing.

91113 Equipment Formula for EQ146 (capsule endoscopy recorder kit)
CA013 + CA016 + 600 minutes recording time of the small bowel capsule + 80 minutes for the images to download to the computer and be processed by the software

The formula above reflects the time the capsule is in use during the preparation of equipment and supplies (CA013), during the preparation of the patient when the capsule is synced to each sensor on the belt and the equipment is connected (CA016), the time the capsule is recording post-ingestion and the time for image download and processing.

91110 Equipment Formula for ES029 (capsule endoscopy video system)
The equipment formula approved by the RUC at the January 2016 RUC meeting (tab 44) for ES029 included 10 minutes to prepare the room, equipment and supplies, 4 minutes to recharge batteries,

initiate data download to workstation, create image archive and 80 minutes for the images to download to the computer and be processed by the software.

The equipment formula we are currently submitting for approval is:
CA013 + CA038 + 80 minutes for the images to download to the computer and be processed by the software

91111 Equipment Formula for ES029 (capsule endoscopy video system)
The equipment formula approved by the RUC at the January 2016 RUC meeting (tab 44) for ES029 included 10 minutes to prepare the room, equipment and supplies, 4 minutes to recharge batteries, initiate data download to workstation, create image archive and 15 minutes for the images to download to the computer and be processed by the software.

The equipment formula we are currently submitting for approval is:
CA013 + CA038 + 15 minutes for the images to download to the computer and be processed by the software

91113 Equipment Formula for ES029 (capsule endoscopy video system)
The equipment formula we are currently submitting for approval is:
CA013 + CA038 + 80 minutes for the images to download to the computer and be processed by the software

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

91110 = 91110
91111 = 91111
91113 = 91110

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 91110, 91111, 91113

SPECIALTY SOCIETY(IES): ACG, AGA, ASGE

PRESENTER(S): R. Bruce Cameron, MD (ACG), Shivan Mehta, MD (AGA), Patricia Garcia, MD (AGA), Seth Gross, MD (ASGE), Vivek Kaul, MD (ASGE)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CUR**
2						**91110**		**91110**		**91**
3		***RUC Collaboration Website***				Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report		Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report		Gastrointe imaging, intr capsule en esopha interpretatio
4	**Clinical Activity Code**	**Meeting Date: 01/2021 Revision Date (if applicable): Tab: 21 Specialty: ACG, AGA, ASGE**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 556.21**	**$ -**	**$ 555.67**	**$ -**	**$ 674.74**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**49.0**	**0.0**	**49.0**	**0.0**	**56.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**41.0**	**0.0**	**41.0**	**0.0**	**48.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 18.13**	**$ -**	**$ 18.13**	**$ -**	**$ 20.72**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37	5		5		5
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37					
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37					
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37					
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3		3		3
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37					
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37					
23			L037D	RN/LPN/MTA	0.37					
26		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are [illegible]	L037D	RN/LPN/MTA	0.37	3		3		3
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5		5		5
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37	3		3		3
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37					
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	10		10		10
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37					
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	6		6		9
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37					
42			L037D	RN/LPN/MTA	0.37					
45		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
48		**Intra-service (of service period)**								
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37					
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37					
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37	4		4		8
55			L037D	RN/LPN/MTA	0.37					
56		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37					
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37					
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	6		6		6
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37					
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37					
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37					
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37					
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and decon cons	L037D	RN/LPN/MTA	0.37					
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	L037D	RN/LPN/MTA	0.37	4		4		4
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37					
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, ECG file, etc.)	L037D	RN/LPN/MTA	0.37					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37					
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**
75			L037D	RN/LPN/MTA	0.37					
78		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37					
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37					
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27							
89		99213 36 minutes	36							
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37					
96		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CUR**
2						**91110**		**91110**		**91**
3		***RUC Collaboration Website***				Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report		Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report		Gastrointe imaging, intr capsule en esopha interpretatio
4	**Clinical Activity Code**	**Meeting Date: 01/2021 Revision Date (if applicable): Tab: 21 Specialty: ACG, AGA, ASGE**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 556.21**	**$ -**	**$ 555.67**	**$ -**	**$ 674.74**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**49.0**	**0.0**	**49.0**	**0.0**	**56.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**41.0**	**0.0**	**41.0**	**0.0**	**48.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 506.58**	**$ -**	**$ 506.53**	**$ -**	**$ 650.87**
102	SA048	pack, minimum multi-specialty visit	4.0507	pack		1		1		1
103	SK087	water, distilled	0.0183	oz		3		**0**		5
104	SK020	drinking straw	0.0175	item		1		1		1
105	SK018	cup, drinking	0.025	item		1		1		1
106	SA005	kit, capsule endoscopy w-application supplies (M2A)	502.435	kit		1		1		
107	SA094	kit, capsule, ESO, endoscopy w-application supplies (ESO)	646.6875	kit						1
108	NEW	PillCam® COLON 2 capsule	625.00	kit						
109	NEW	PillCam® sensor sleeves	5.00	item				0		
110		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
112	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
113		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 31.50**	**$ -**	**$ 31.01**	**$ -**	**$ 3.15**
114	ES029	video system, capsule endoscopy (software, computer, monitor, printer)	$ 10,181.55	Other Formula	0.040341284	94		90		29
115	EQ146	kit, capsule endoscopy recorder	$ 17,701.58	Other Formula	0.046975154	583		576		34
116	EF023	table, exam	$ 3,887.84	Default	0.008648083	37		37		44
117										
120		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	L	M	N	O	P	Q	R
1	RUC Practice Expense Spreadsheet		RENT	RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2			111	91111		91110		91113	
3		***RUC Collaboration Website***	stinal tract	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report		Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report		Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	
4	Clinical Activity Code	**Meeting Date: 01/2021** **Revision Date (if applicable):** **Tab: 21** **Specialty: ACG, AGA, ASGE**	aluminal (eg, doscopy), gus with n and report						
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 675.90**	**$ -**	**$ 556.21**	**$ -**	**$ 688.41**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**56.0**	**0.0**	**49.0**	**0.0**	**61.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**48.0**	**0.0**	**41.0**	**0.0**	**53.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ 20.72**	**$ -**	**$ 18.13**	**$ -**	**$ 22.57**	**$ -**
13		**PRE-SERVICE PERIOD**							
14		**Start: Following visit when decision for surgery/procedure made**							
15	CA001	Complete pre-service diagnostic and referral forms		5		5		5	
16	CA002	Coordinate pre-surgery services (including test results)							
17	CA003	Schedule space and equipment in facility							
18	CA004	Provide pre-service education/obtain consent							
19	CA005	Complete pre-procedure phone calls and prescription		3		3		3	
20	CA006	Confirm availability of prior images/studies							
21	CA007	Review patient clinical extant information and questionnaire							
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)							
23									
26		*Other activity: please include short clinical description here and type new in column A*							
29		**End: When patient enters office/facility for surgery/procedure**							
30		**SERVICE PERIOD**							
31		**Start: When patient enters office/facility for surgery/procedure:**							
32		**Pre-Service (of service period)**							
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are [illegible]		3		3		3	
34	CA010	Obtain vital signs		5		5		5	
35	CA011	Provide education/obtain consent		3		3		9	
36	CA012	Review requisition, assess for special needs							
37	CA013	Prepare room, equipment and supplies		10		10		10	
38	CA014	Confirm order, protocol exam							
39	CA015	Setup scope (nonfacility setting only)							
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient		9		6		6	
41	CA017	Sedate/apply anesthesia							
42									
45		*Other activity: please include short clinical description here and type new in column A*							
48		**Intra-service (of service period)**							
49	CA018	Assist physician or other qualified healthcare professional---directly							
50	CA019	Assist physician or other qualified healthcare professional---directly							
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)							
52	CA021	Perform procedure/service---NOT directly related to physician work time		8		4		10	
55									
56		*Other activity: please include short clinical description here and type new in column A*							
59		**Post-Service (of service period)**							
60	CA022	Monitor patient following procedure/service, multitasking 1:4							
61	CA023	Monitor patient following procedure/service, no multitasking							
62	CA024	Clean room/equipment by clinical staff		6		6		6	
63	CA025	Clean scope							
64	CA026	Clean surgical instrument package							
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions							
66	CA028	Review/read post-procedure x-ray, lab and pathology reports							
67	CA029	Check dressings, catheters, wounds							
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page							
69	CA031	Review examination with interpreting MD/DO							
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue		4		4		4	
71	CA033	Perform regulatory mandated quality assurance activity (service period)							
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, ESC file, etc.)							
73	CA035	Review home care instructions, coordinate visits/prescriptions							
74	CA036	Discharge day management		n/a		n/a		n/a	
75									
78		*Other activity: please include short clinical description here and type new in column A*							
81		**End: Patient leaves office/facility**							
82		**POST-SERVICE PERIOD**							
83		**Start: Patient leaves office/facility**							
84	CA037	Conduct patient communications							
85	CA038	Coordinate post-procedure services							
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes							
88		99212 27 minutes							
89		99213 36 minutes							
90		99214 53 minutes							
91		99215 63 minutes							
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93									
96		*Other activity: please include short clinical description here and type new in column A*							
99		**End: with last office visit before end of global period**							

	A	B	L	M	N	O	P	Q	R
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2			**111**	**91111**		**91110**		**91113**	
3		***RUC Collaboration Website***	stinal tract	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report		Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report		Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	
4	**Clinical Activity Code**	**Meeting Date: 01/2021** **Revision Date (if applicable):** **Tab: 21** **Specialty: ACG, AGA, ASGE**	aluminal (eg, doscopy), gus with n and report						
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 675.90**	**$ -**	**$ 556.21**	**$ -**	**$ 688.41**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**56.0**	**0.0**	**49.0**	**0.0**	**61.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**	**8.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**48.0**	**0.0**	**41.0**	**0.0**	**53.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ 650.78**	**$ -**	**$ 506.58**	**$ -**	**$ 629.09**	**$ -**
102	SA048	pack, minimum multi-specialty visit		1		1		1	
103	SK087	water, distilled		**0**		3		**0**	
104	SK020	drinking straw		1		1		1	
105	SK018	cup, drinking		1		1		1	
106	SA005	kit, capsule endoscopy w-application supplies (M2A)				1			
107	SA094	kit, capsule, ESO, endoscopy w-application supplies (ESO)		1					
108	NEW	PillCam® COLON 2 capsule						1	
109	NEW	PillCam® sensor sleeves		0				0	
110		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
112	**Equipment Code**	**EQUIPMENT**							
113		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ 4.40**	**$ -**	**$ 31.50**	**$ -**	**$ 36.75**	**$ -**
114	ES029	video system, capsule endoscopy (software, computer, monitor, printer)		25		94		90	
115	EQ146	kit, capsule endoscopy recorder		64		583		696	
116	EF023	table, exam		44		37		49	
117									
120		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*							

December 11, 2020

Scott Manaker, MD, PhD
RUC Practice Expense Subcommittee Chair
AMA Department of Physician Payment Policy and Systems
330 North Wabash, Office 45-372
Chicago, IL 60611

Subject: PE for Tab 21 - 91110, 91111 and 91113

Dear Dr. Manaker,

The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and the American Society for Gastroenterology (ASGE) is not submitting facility practice expense recommendations for 91110, 91111 and 91113 as these codes are not performed in the facility setting:

91110 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report

91111 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report

91113 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report

We look forward to discussing practice expense for Tab 21 with the Practice Expense Subcommittee at the January 2021 meeting.

Sincerely,

R. Bruce Cameron, MD
RUC Advisor
American College of Gastroenterology

Shivan Mehta, MD
RUC Advisor
American Gastroenterological Association

Seth A. Gross, MD
RUC Advisor
American Society for Gastrointestinal Endoscopy

AMA/Specialty Society RVS Update Committee Summary of Recommendations
**** High Volume Growth****

January 2021

Cardiac Ablation – Tab 22

The RUC identified CPT code 93656 with Medicare utilization over 10,000 that have increased by at least 100% from 2014 through 2019e. In January 2020, the RUC recommended to refer this issue to the CPT Editorial Panel in May 2020 for revision and bundling. Technology and clinical practice have changed since these codes were developed in 2011. Based on the billed together data for these and related codes, the specialty societies recommended referral to CPT to update code descriptors and likely bundle services now commonly performed together, such as 3D mapping. In October 2020, the CPT Editorial Panel revised one code (93653) to bundle with 3D mapping and to include "induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus," and another (93656) to add 3D mapping and "left atrial pacing and recording from coronary sinus or left atrium" and "intracardiac echocardiography including imaging supervision and interpretation" to their descriptors.

Rationale for Interim Recommendation
The specialties submitted a letter to the CPT Editorial Panel on December 14, 2020 requesting for the coding changes for these services to be rescinded for CPT 2022; however, as this request will not be considered until after the January 2021 RUC meeting and January 2021 is the last RUC meeting of the CPT 2022 cycle, the specialties have made a separate request to the RUC for the RUC's recommendations for these services to be interim.

During the presentation to the RUC, the specialties noted that despite the inclusion of comprehensive changes to the CPT introductory language, their multispecialty advisory committee believed that many of the survey respondents did not realize that the codes had been revised. The specialties noted that they inferred that this occurred because respondents may not have read the updated code descriptors thoroughly and that a contributing factor may be that the CPT code numbers did not change. Given respondents' familiarity with the existing code numbers, and their current ability to separately report the newly bundled services, the specialties asserted that there is a strong possibility that many of the survey participants based their assumptions on the current reporting rules where several services are separately reportable. The RUC discussed whether the survey respondents were confused by the change in reporting rules for this family of services. Although several RUC members did note that the survey physician times for 93654 seemed to be potentially incongruent with 93653 and 93656, the RUC noted that it was unclear whether most of the survey respondents understood the coding changes. **The RUC recommends for these services to be valued as interim and that these services will be resurveyed and reviewed at the April 2021 RUC meeting.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

93653 ***Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry***
The RUC reviewed the survey results from 74 cardiac electrophysiologists and recommends the survey median work RVU of 18.49 for CPT code 93653. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait time, 125 minutes of intra-service time and 30 minutes of immediate post-service time. The RUC noted that CPT code 93653 was revised to now bundle the physician work of CPT codes 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* and 93621 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)*, which previously were separately reported add-on services.

To justify a value of 18.49, the RUC compared the survey code to top key reference code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, intra-service time of 120 minutes, total time of 210 minutes) and noted that the survey code involves 5 more minutes of intra-service time and that 89 percent of the survey respondents that selected the top key reference code had also indicated that the survey code is a more intense and complex procedure to perform. The RUC also compared the survey code to CPT code 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU= 21.70, intra-service of 135 minutes, total time of 223 minutes) and noted that the reference code involves 10 more minutes of intra-service time and total time and is a somewhat more intense service to perform, supporting a somewhat lower value for the survey code. The specialty noted and the RUC concurred that there are very few major surgical procedures that are 000-day or XXX to use as reference codes to compare to the survey code. **The RUC recommends an interim work RVU of 18.49 for CPT code 93653.**

93654 ***Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed***
The RUC reviewed survey results from 73 cardiac electrophysiologists and agreed that the survey respondents, with a 25th percentile work value of 20.00, narrowly overvalued the physician work involved in performing this service. The RUC recommends maintaining the current value of 19.75 for CPT code 93654. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 20 minutes of pre-service scrub/dress/wait time, 240 minutes of intra-service time and 33 minutes of immediate post-service time.

To justify a work value of 19.75, the RUC compared the survey code to top key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that the survey code involves 40 more minutes of intra-service time and 66 more minutes of total time. The specialty noted that the survey times for this service relative to the other services in this tab, which were all surveyed on the same survey instrument, made them think the survey respondents may not have considered the bundling of 3D mapping for the services in this tab. CPT code 93654 previously included 3D mapping, whereas the other services in the tab are newly having that work bundled in. The specialty noted and the RUC concurred that there are very few

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

major surgical procedures that are 000-day or XXX to use as reference codes to compare to this survey code. **The RUC recommends an interim work RVU of 19.75 for CPT code 93654.**

93655 ***Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 74 cardiac electrophysiologists and agreed that the survey respondents, with a 25th percentile work value of 8.00, overvalued the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)* (work RVU= 6.50, intra-service and total time of 60 minutes) would be appropriate, as both add-on services typically involve an identical amount of time and physician work intensity to perform. The RUC recommends 60 minutes of intra-service time for CPT code 93655

CPT codes 93653, 93654 and 93656 are the three base codes that add-on code 93655 will be reported with. All three of these base codes will have the work of 3D mapping bundled in. The RUC noted that 93655 is most often an add-on code reported with 93656 (83% of the time per 2018 Medicare 5% file).

To further support a work value of 6.50, the RUC compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 7.00, intra-service and total time of 60 minutes) and noted that both services have identical times, whereas the reference service is a slightly more intense procedure to perform. **The RUC recommends an interim work RVU of 6.50 for CPT code 93655.**

93656 ***Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed***
The RUC reviewed the survey results from 73 cardiac electrophysiologists and recommends the survey 25th percentile work RVU of 20.00 for CPT code 93656. The RUC recommends 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 20 minutes of pre-service scrub/dress/wait time, 210 minutes of intra-service time and 33 minutes of immediate post-service time. The RUC noted that CPT code 93656 was revised to now bundle the physician work of CPT codes 93613 *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)* and 93662 *Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)*, which previously were separately reported add-on services.

To justify a value of 20.00, the RUC compared the survey code to 2nd key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that the survey code involves 30 more minutes of intra-service time and 36 more minutes of total time. The RUC also compared the survey code to

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200, total time of 355) and noted that although the survey code involves 10 more minutes of intra-service time, the reference code includes 49 more minutes of total time, justifying a lower valuation for the survey code. The specialty noted and the RUC concurred that there are very few major surgical procedures that are 000-day or XXX to use as reference codes to compare to this survey code. **The RUC recommends an interim work RVU of 20.00 for CPT code 93656.**

93657 ***Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)***
The RUC reviewed survey results from 74 cardiac electrophysiologists and agreed that the survey respondents, with a 25th percentile work value of 8.00, overvalued the physician work involved in performing this service. The RUC determined that a direct work RVU crosswalk to CPT code 34709 *Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)* (work RVU= 6.50, intra-service and total time of 60 minutes) would be appropriate, as both add-on services typically involve an identical amount of time and physician work intensity to perform. The RUC recommends 60 minutes of intra-service time.

To further support a work value of 6.50, the RUC compared the survey code to CPT code 34820 *Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)* (work RVU= 7.00, intra-service and total time of 60 minutes) and noted that both services have identical times, whereas the reference service is a slightly more intense procedure to perform. **The RUC recommends an interim work RVU of 6.50 for CPT code 93657.**

Practice Expense
No direct practice expense inputs are recommended for CPT codes 93653-93657 as they are facility-only services.

Bundled Add-on Services for Next LOI
A RUC member noted that even though the work of add-on services 93613, 93621 and 93662 are being bundled into CPT codes 93653 and/or 93656, these add-on codes are being retained as they may also be reported with other CPT codes. However, these services are each typically reported with either 93653 or 93656 in the 2018 Medicare billed together data. These services will be added to the LOI along with 93653-93657 for the April 2020 RUC meeting.

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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine **Cardiovascular** **Intracardiac Electrophysiological Procedures/Studies**				
▲93653	Y1	Comprehensive electrophysiologic evaluation ~~including~~ with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including ~~with~~ intracardiac electrophysiologic 3-dimensional mapping, ~~induction or attempted induction of an arrhythmia with right atrial pacing and recording,~~ right ventricular pacing and recording, ~~(when necessary),~~ left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed ~~(when necessary),with intracardiac catheter ablation of arrhythmogenic focus~~; ~~with~~ treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry (Do not report 93653 in conjunction with 93600, 93602, 93603, 93610, 93612, 93613, 93618, 93619, 93620, 93621, 93642, 93654, 93656)	000	18.49 *(Interim)*
▲93654	Y2	with treatment of ventricular tachycardia or focus of ventricular ectopy including ~~intracardiac electrophysiologic 3D mapping, when performed, and~~ left ventricular pacing and recording, when performed (Do not report 93654 in conjunction with 93279-93284, 93286-93289, 93600-93603, 93609, 93610, 93612, 93613, 93618-93620, 93622, 93642, 93653, 93656)	000	19.75 *(Interim)* *(No Change)* *2021 Work RVU = 19.75*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(f)93655	Y3	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure) (Use 93655 in conjunction with 93653, 93654, 93656)	ZZZ	6.50 *(Interim)*
▲93656	Y4	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, ~~when necessary,~~ right ventricular pacing/recording, ~~when necessary~~, and His bundle recording, when performed~~necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation~~ (Do not report 93656 in conjunction with 93279, 93280, 93281, 93282, 93283, 93284, 93286, 93287, 93288, 93289, 93462, 93600, 93602, 93603, 93610, 93612, 93613, 93618, 93619, 93620, 93621, 93653, 93654, 93662)	000	20.00 *(Interim)*
(f)93657	Y5	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure) (Use 93657 in conjunction with 93656)	ZZZ	6.50 *(Interim)*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

	Elements of Cardiac Ablation Codes								
	93653 SVT Ablation			93654 VT Ablation			93656 AF Ablation		
Procedure/Services included with Ablations	Required	Bundled	Not Bundled, Sometimes Performed	Required	Bundled	Not Bundled, Sometimes Performed	Required	Bundled	Not Bundled, Sometimes Performed
Insert/reposition multiple catheters	X			X			X		
Transseptal catheterization(s) (93462)							X		
Induction or attempted induction of arrhythmia with Right Atrial pacing and recording	X			X				X	
Intracardiac ablation of arrhythmia	X			X			X		
SVT Ablation	X								
VT Ablation				X					
AF ablation							X		
Intracardiac 3d mapping (93613)		X			X			X	
Right Ventricular pacing and recording		X			X			X	
Left Atrial pacing and recording from coronary sinus or Left Atrium (93612)		X			X			X	
His Bundle recording		X			X			X	
Left Ventricular pacing and recording					X				
Intracardiac Echocardiography (93662)			X			X		X	

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

December 14, 2020

Mark Synovec, MD
Chair, CPT Editorial Panel
American Medical Association
330 N. Wabash Avenue, Suite 39300
Chicago, IL 60611-5585

RE: October 2020 CPT Tab 61/January 2021 RUC Tab 22

Dear Dr. Synovec:

As the RUC and CPT Advisors for the Heart Rhythm Society and the American College of Cardiology, we request that the CPT Executive Committee rescind the Panel's October 2020 decision to revise codes 93653, 93654 and 93656 describing electrophysiology study with cardiac ablation services. The societies are struggling to develop work RVU recommendations and believe additional time would facilitate accurate work estimation.

Two of the five codes in the family include newly bundled work (93653, 93656). A third code was revised to move the bundled service into the primary code (93654). Our RUC expert panel was surprised to see the magnitude of change reported in the work survey data, especially for codes where additional elements are newly bundled. Following a number of conversations among staff and advisors, we have no confidence in the survey data that we received.

Despite the inclusion of comprehensive materials, we believe that our survey respondents did not realize that the codes had been revised. We infer that this occurred because respondents may not have read the updated code descriptors thoroughly. A contributing factor may be that the code numbers did not change. Given respondents' familiarity with the existing code numbers, and their current ability to separately bill for the newly bundled services, we think that the survey participants based their assumptions on current billing rules.

Were this not the last meeting of the CPT cycle, we would submit to the RUC the survey data and a letter with a plan to resurvey, explaining our concerns and items we plan to take up with the Research Subcommittee to obtain a more accurate response. However, since this is the last meeting in the cycle that approach is not possible. We intend to recommend interim values to the RUC at the January meeting and seek to modify elements of the survey and/or related survey materials to make these bundling changes clearer to respondents.

Unfortunately, there is no guarantee CMS would accommodate any updated recommendations from the April RUC meeting for 2022 rulemaking. Thus, our request to rescind the October outcome of Tab 61. Because we think some of the difficulty stemmed from use of the same code number for the newly

bundled codes, we request CPT delay publication of these codes until 2023, allowing us to execute the resurvey without introducing uncertainty from CMS. We have already raised several possible modifications with RUC staff, including utilizing "dummy" codes for the survey to prompt respondents to think of the items under review as new codes.

It is not necessarily part of our request that new code numbers be assigned to these services. We understand a process already exists to consider whether new code numbers are needed and that the code change application did not indicate a need for new numbers. Using the above-mentioned tactic of "dummy" codes in the RUC survey would accomplish the same thing from a work valuation perspective. This exercise could become a test case for something the RUC may want to standardize, for future bundled services, and may also warrant a separate rethinking of when new codes are assigned.

Thank you for your consideration of this request. Please contact society staff if additional information would be helpful for you and the Executive Committee, or if there are other solutions we should explore.

Sincerely,

JoEllyn Moore, MD
HRS CPT Advisor

Randall Thompson, MD
ACC CPT Advisor

Mark Schoenfeld, MD
HRS RUC Advisor

Richard Wright, MD
ACC RUC Advisor

cc: Sherry Smith
Zachary Hochstetler

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93653 Tracking Number Y1 Original Specialty Recommended RVU: **18.49**
Presented Recommended RVU: **18.49**
Global Period: 000 Current Work RVU: **14.75** RUC Recommended RVU: **18.49**

CPT Descriptor: Comprehensive electrophysiologic evaluation including with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry
(Do not report 93653 in conjunction with 93600, 93602, 93603, 93610, 93612, 93613, 93618, 93619, 93620, 93621, 93642, 93654, 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old female has recurrent palpitations. an event monitor has documented supraventricular tachycardia (svt). a comprehensive electrophysiologic evaluation with catheter ablation is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The procedure and the risks, benefits, and alternatives associated with electrophysiology testing and supraventricular tachycardia ablation are explained to the patient. Management of antiarrhythmic medications is communicated to the patient. Arrangements are made for the X-ray technician, electrophysiology laboratory technician, and nurse. Informed consent is obtained. The patient is evaluated on the day of the procedure with a history and physical examination. Preprocedure laboratory testing is reviewed as well as current medications and changes in health status.

Description of Intra-Service Work: Direct current cardioversion/defibrillation and electrophysiology (EP) testing/ablation equipment is confirmed to be present and in proper working order. Fluoroscopic equipment that will be used to visualize catheter movements and location is tested. Local analgesia is administered along with anesthesia appropriate to the patient including moderate sedation. Venous access is obtained. Arterial access to monitor blood pressure and to facilitate retrograde aortic access to the left ventricle may be obtained. Multi-electrode catheters are advanced from the access sheaths and into the respective cardiac chambers where they will be used to pace and record. Pacing and sensing is performed in the right atrium, left atrium, and right ventricle. His bundle recording is obtained. Refractory periods are measured. Attempts at arrhythmia induction are performed via maneuvers that include burst pacing and premature pacing using programmed electrical stimulation at multiple drive cycle lengths from multiple atrial and ventricular sites.

Once the SVT is induced, pacing maneuvers are performed to elucidate the mechanism of the tachycardia. A combination of diagnostic maneuvers is performed and a high definition anatomical map of the chamber(s) of interest is generated. Voltage and electrical activation in the arrhythmia and/or in sinus rhythm is performed to identify normal activation, location of scar, and mechanism of the arrhythmia. Catheter ablation may then be performed. An ablation catheter is maneuvered from the sites of vascular access to the appropriate cardiac location to facilitate delivery of ablative energy. Multiple lesions are delivered to ensure eradication of the arrhythmia focus and to provide consolidation lesions in the surrounding tissue.

During the course of an electrophysiology procedure, an arrhythmia is induced that requires use of advanced 3D computer mapping system to assist in identifying the arrhythmia circuit, localizing the origin (for focal arrhythmias) or the critical isthmus (reentrant arrhythmias). The 3D mapping system is calibrated, and recordings are made during sinus rhythm (to identify normal activation and location of scar) and during each distinct arrhythmia. The physician then analyzes the computer-generated map, ensuring that electrograms are annotated correctly and that the display parameters are correct for the specific arrhythmia being mapped. Based upon the data from the 3D mapping system, endocardial electrograms, surface ECG and the response of the SVT to pacing maneuvers, the ablation catheter is advanced to the point of earliest activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Radiofrequency (or cryo) ablation is then performed. If initial mapping in one chamber does not lead to complete identification of the essential arrhythmia circuit (either based on analysis of the map or based on incomplete ablation result, then the mapping catheter(s) is/are moved into another cardiac chamber and an additional 3D map is generated to aid in diagnosis; this is repeated until the arrhythmia mechanism is fully characterized and ablation is deemed completely successful. A final report that includes the mapping procedure and findings is prepared.

To record left atrial activity, femoral venous access site is already prepared for related procedure. Achieve central venous access, place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access if that fails. Introduce the catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus is engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac electrophysiology procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report.

Throughout the ablation the patient is monitored for hemodynamic compromise due to cardiac perforation, - or tachyarrhythmias, embolic phenomena, or damage to cardiac or vascular structures. Following the ablation portion of the procedure, repeat electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. These are again repeated following a 30-minute waiting period following the conclusion of the final ablation lesion. If the tachycardia demonstrates recovery or incomplete suppression, then repeat mapping and ablation are performed as described above. These steps are repeated until the tachycardia is rendered durably suppressed. Sheaths are removed, appropriate hemostasis is achieved, and follow-up assessment of the patient for any complications is performed.

Description of Post-Service Work: The patient is monitored in the recovery unit for delayed complications. Results of the procedure are discussed with the patient and the patient's family, and postprocedure assessments are performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93653					
Sample Size:	941	**Resp N:**	74			
Description of Sample:	randomly selected electrophysiologists from the two societies					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	27.00	**40.00**	60.00	110.00	
Survey RVW:	8.00	15.00	**18.49**	22.76	30.00	
Pre-Service Evaluation Time:			**50.00**			
Pre-Service Positioning Time:			**15.00**			
Pre-Service Scrub, Dress, Wait Time:			**15.00**			
Intra-Service Time:	60.00	120.00	**125.00**	180.00	240.00	
Immediate Post Service-Time:	**30.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93653	**Recommended Physician Work RVU: 18.49**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**125.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33340	000	14.00	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 **% of respondents:** 36.4 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 17.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 93653	Top Key Reference CPT Code: 93580	2nd Key Reference CPT Code: 33340
Median Pre-Service Time	58.00	30.00	40.00
Median Intra-Service Time	125.00	120.00	90.00
Median Immediate Post-service Time	30.00	60.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**213.00**	**210.00**	**160.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	7%	44%	45%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	19%	77%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	11%	85%
Physical effort required	0%	33%	87%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	22%	74%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	15%	62%	23%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	8%	84%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	31%	69%
Physical effort required	0%	38%	62%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	15%	23%	62%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified

that CPT 93653 (SVT ablation) should have services bundled into it before the codes are re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: **93653**, 93654, 93655, 93656, 93657. As indicated in the summary spreadsheet, revised 93653 is now a more comprehensive, bundled service that includes the work of 3D mapping (93613) and left atrial pacing/recording (93621).

The ACC and HRS randomly surveyed cardiac electrophysiologists, as designated by membership rolls, on the newly created codes and entire family. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service.

The key reference code is 93580 for percutaneous transcatheter closure of a congenital interatrial communication. It was selected by approximately 36% of respondents. 89% of the respondents indicated that 93653 was more complex. The second reference code was 33340 for percutaneous transcatheter closure of left atrial appendage with endocardial implant. It was selected by approximately 18% of respondents. About 85% of the respondents indicated that 93653 was more intense/complex overall.

Survey Concerns

In reviewing the survey data to develop work recommendations, the expert panel quickly developed doubts about the validity of the survey results for the newly bundled services, 93653 and 93656. In both instances, intraservice procedure times dropped significantly, despite the inclusion of the newly bundled elements. After deliberation, the expert panel concluded that we do not believe survey respondents thoroughly understood that 3D mapping and left atrial pacing were now inherent to 93653. This is despite language in the survey invitation and coding changes document (both attached).

We believe this may have occurred for two reasons. One is that despite providing information about the elements of the revised code, survey respondents still saw the same code number, 93653, and may have incorrectly believed the code descriptor was unchanged. The second reason is that when we compared the newly revised codes to code 93654 which did not undergo any revisions, that service came back with an identical intraservice procedure time and quite consistent work RVUs.

We can certainly think of reasons—mostly changes in technology and broader service dispersion—that intraservice times would decline somewhat after nearly a decade. However, the magnitude of the change does not comport with our professional experience. And these doubts are compounded by the absence of change in 93654, making us think something did not register for survey respondents.

Therefore, as part of this package of recommendations, we are also recommending the ultimate RUC value recommendations be made on an interim basis with a plan to resurvey these codes for the April RUC meeting. We have already developed several survey tool changes for which we will seek Research Subcommittee approval, attempting to more actively prompt survey respondents to incorporate the new elements of the bundled service. One such tactic is to use a "dummy" code so they do not immediately perceive familiarity with the code descriptor. Another is to include a redline version of the code descriptor in the survey itself. Yet another is to more explicitly inform respondents in the invitation which elements have been bundled.

Since this is the last meeting of the 2022 CPT cycle, we have separately requested the CPT Editorial Panel withhold publication of these codes until 2023. (attached) We do not know the outcome of that request and are preparing to resurvey regardless. However, as noted in that letter, it is uncertain whether CMS would accommodate late information from the April RUC meeting. Delaying publication of the revised codes is the surest way to avoid the possibility that inaccurate work RVUs are deployed in the 2022 fee schedule. Finally, we fully recognize that we may undertake this effort and still end up with similar results, but we believe the effort is worthwhile given our concerns with this initial survey data.

Recommendation

Therefore, for code 93653 the **societies recommend, <u>as an interim value</u>, the survey median RVW of 18.49 with 63 minutes preservice time from package 4, 125 minutes intraservice time from the survey median, and 30 minutes postservice time with 3 minutes removed from package 9B**. This aligns closely with the KRS 93580 in terms of IWPUT, WPUT, total time, and intraservice time. Survey respondents felt 93580 was less complex and had a shorter preservice time than 93652. This recommendation also produces a work RVU savings from the current, component-coded services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93653, 93613, 93621

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 63642
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is about twicethe Medicare-based claims volume.

Specialty Cardiac electrophysiology Frequency 50022 Percentage 78.59 %

Specialty Cardiology Frequency 11902 Percentage 18.70 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 31,821 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects 2019e Medicare-based claims.

Specialty Cardiac electrophysiology Frequency 25009 Percentage 78.59 %

Specialty Cardiology Frequency 5951 Percentage 18.70 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93653

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93654 Tracking Number Y2 Original Specialty Recommended RVU: **19.75**
Presented Recommended RVU: **19.75**
Global Period: 000 Current Work RVU: **19.75** RUC Recommended RVU: **19.75**

CPT Descriptor: Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording,left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed
(Do not report 93654 in conjunction with 93279-93284, 93286-93289, 93600-93603, 93609, 93610, 93612, 93613, 93618-93620, 93622, 93642, 93653, 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old male with a history of new york heart association class iii heart failure due to ischemic dilated cardiomyopathy (ef 25%) and prior myocardial infarction presents with recurrent implantable cardioverter-defibrillator (icd) therapies for drug-refractory ventricular tachycardia.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Transthoracic echocardiography and, if necessary, transesophageal echocardiography are obtained prior to the procedure to rule out left ventricular thrombus and to assess the aortic arch for presence of atherometous plaques. The procedure and the risks, benefits, and alternatives associated with electrophysiology testing and ventricular tachycardia ablation are explained to the patient and the patient's family. Arrangements are made for the X-ray technician, electrophysiology laboratory technician, and nurse. The patient is evaluated on the day of the procedure with a history and physical examination and pre-procedure laboratory testing, medications, and changes in heath are reviewed. Informed consent is obtained.

Description of Intra-Service Work: Direct current cardioversion/defibrillation, electrophysiology (EP), and ablation equipment is confirmed to be present and in proper working order. Fluoroscopic equipment that will be used to visualize catheter movements and location is tested. Three-dimensional mapping equipment is tested and confirmed to be functioning normally. Local analgesia is administered. Patients with implantable cardioverter-defibrillators will have their devices reprogrammed and/or transiently deactivated at the start of the case so as to minimize adverse consequences resulting from electromagnetic interference from radiofrequency current application.

Venous access is obtained. Arterial access to monitor blood pressure and to facilitate retrograde aortic access to the left ventricle is obtained. Multi-electrode catheters are advanced from the access sheaths and into the respective cardiac chambers where they will be used to pace and record. An intracardiac echo probe is placed via a femoral venous access approach. The intracardiac echo is used in conjunction with the three-dimensional mapping system to create a three-dimensional shell of the right or left ventricle, including the aortic root, aortic valve leaflets, coronary sinus, and mitral valve annulus. Papillary muscles are also recorded in the three-dimensional anatomical ultrasound map. Pacing and sensing is performed in the right atrium and right ventricle. His bundle recording is obtained. Refractory periods are

measured. Attempts at ventricular tachycardia induction are performed via burst pacing, decremental pacing, and premature pacing using programmed electrical stimulation at multiple drive cycle lengths from multiple ventricular sites.
To record left atrial activity, femoral venous access site is already prepared for related procedure. Achieve central venous access, place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access if that fails. Introduce the catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus is engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac electrophysiology procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report.

Once an arrhythmia is induced, pacing maneuvers are performed to elucidate the mechanism of the ventricular tachycardia. During the course of an electrophysiology procedure, an arrhythmia is induced that requires use of advanced 3D computer mapping system to assist in identifying the arrhythmia circuit, localizing the origin (for focal arrhythmias) or the critical isthmus (reentrant arrhythmias). The 3D mapping system is calibrated, and recordings are made during sinus rhythm (to identify normal activation and location of scar) and during each distinct arrhythmia. The physician then analyzes the computer-generated map, ensuring that electrograms are annotated correctly and that the display parameters are correct for the specific arrhythmia being mapped. Based upon the data from the 3D mapping system, endocardial electrograms, surface ECG and the response of the SVT to pacing maneuvers, the ablation catheter is advanced to the point of earliest activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Radiofrequency (or cryo) ablation is then performed. If initial mapping in one chamber does not lead to complete identification of the essential arrhythmia circuit (either based on analysis of the map or based on incomplete ablation result, then the mapping catheter(s) is/are moved into another cardiac chamber and an additional 3D map is generated to aid in diagnosis; this is repeated until the arrhythmia mechanism is fully characterized and ablation is deemed completely successful. Occasionally mapping of the epicardial surface of the heart is necessary. A final report that includes the mapping procedure and findings is prepared.
The electrical activation sequence is mapped with the three-dimensional electroanatomical mapping system and activation timing is superimposed upon the three-dimensional echo image previously obtained. Anticoagulation is administered once catheters have been placed on the left side of the heart. Once the ventricular tachycardia circuit is localized, a catheter is moved to the appropriate location or region of abnormal myocardium to deliver ablative energy. Multiple lesions are delivered to ensure eradication of the arrhythmia focus and to provide consolidation lesions in the surrounding tissue. Throughout the ablation the patient is monitored for hemodynamic compromise due to cardiac perforation, - or tachyarrhythmias, embolic phenomena, or damage to cardiac or vascular structures.

Following the ablation portion of the procedure, repeat electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. These are again repeated following a 30-minute waiting period following the conclusion of the final ablation lesion. If the tachycardia demonstrates recovery or incomplete suppression, then repeat mapping and ablation are performed as described above. These steps are repeated until the tachycardia is rendered durably suppressed. Following the ablation portion of the procedure, further electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. These are repeated following a 30-minute period following the conclusion of the final ablation lesion. Anticoagulation is reversed. Sheaths are removed, appropriate hemostasis is achieved, and follow-up assessment of the patient for any complications is performed. Patients with implantable cardioverter-defibrillators will have their devices reprogrammed to an active configuration with rates reprogrammed as necessary to treat any remaining arrhythmias.

Description of Post-Service Work: The patient is monitored in the recovery unit and then overnight in a telemetry unit for delayed complications. Results of the procedure are discussed with the patient and the patient's family, and postprocedure assessments are performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93654					
Sample Size:	941	**Resp N:**	73			
Description of Sample:	randomly selected electrophysiologists from the two societies					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	10.00	**20.00**	30.00	200.00	
Survey RVW:	10.00	20.00	**25.00**	30.00	50.00	
Pre-Service Evaluation Time:			**62.00**			
Pre-Service Positioning Time:			**20.00**			
Pre-Service Scrub, Dress, Wait Time:			**20.00**			
Intra-Service Time:	60.00	180.00	**240.00**	282.00	480.00	
Immediate Post Service-Time:	**45.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93654	**Recommended Physician Work RVU: 19.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**240.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**33.00**	**33.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93581	000	24.39	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 **% of respondents:** 39.7 **%**

Number of respondents who choose 2nd Key Reference Code: 28 **% of respondents:** 38.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 93654	Top Key Reference CPT Code: 93581	2nd Key Reference CPT Code: **93580**
Median Pre-Service Time	63.00	30.00	30.00
Median Intra-Service Time	240.00	180.00	120.00
Median Immediate Post-service Time	33.00	60.00	60.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**336.00**	**270.00**	**210.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	3%	21%	76%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	7%	93%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	7%	93%
Physical effort required	0%	21%	79%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	21%	79%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	4%	21%	75%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	7%	93%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	7%	93%
Physical effort required	0%	14%	86%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	7%	93%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the

codes are re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: 93653 and 93656, and were tasked in surveying the other codes in the family: 93654, 93655, and 93657.

The ACC and HRS randomly surveyed cardia electrophysiologists, as designated by membership rolls, on the newly created codes. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. This is the last of three new codes to report endovascular repair of aortic coarctation.

The key reference code is 93581 for percutaneous transcatheter closure of a congenital ventricular septal defect. It was selected by approximately 40% of respondents. 96% of the respondents indicated that 93654 was more complex. The second reference code was 93580 for percutaneous transcatheter closure of congenital interatrial communication. It was selected by approximately 38% of respondents. About 97% of the respondents indicated that 93654 was more intense/complex overall.

Survey Concerns

In reviewing the survey data to develop work recommendations, the expert panel quickly developed doubts about the validity of the survey results for the newly bundled services, 93653 and 93656. In both instances, intraservice procedure times dropped significantly, despite the inclusion of the newly bundled elements. After deliberation, the expert panel concluded that we do not believe survey respondents thoroughly understood that 3D mapping and left atrial pacing were now inherent to 93653. This is despite language in the survey invitation and coding changes document (both attached).

We believe this may have occurred for two reasons. One is that despite providing information about the elements of the revised code, survey respondents still saw the same code number, 93653, and may have incorrectly believed the code descriptor was unchanged. The second reason is that when we compared the newly revised codes to code 93654 which did not undergo any revisions, that service came back with an identical intraservice procedure time and quite consistent work RVUs.

We can certainly think of reasons—mostly changes in technology and broader service dispersion—that intraservice times would decline somewhat after nearly a decade. However, the magnitude of the change does not comport with our professional experience. And these doubts are compounded by the absence of change in 93654, making us think something did not register for survey respondents.

Therefore, as part of this package of recommendations, we are also recommending the ultimate RUC value recommendations be made on an interim basis with a plan to resurvey these codes for the April RUC meeting. We have already developed several survey tool changes we for which we will seek Research Subcommittee approval, attempting to more actively prompt survey respondents to incorporate the new elements of the bundled service. One such tactic is to use a "dummy" code so they do not immediately perceive familiarity with the code descriptor. Another is to include a redline version of the code descriptor in the survey itself. Yet another is to more explicitly inform respondents in the invitation which elements have been bundled.

Since this is the last meeting of the 2022 CPT cycle, we have separately requested the CPT Editorial Panel withhold publication of these codes until 2023. (attached) We do not know the outcome of that request and are preparing to resurvey regardless. However, as noted in that letter, it is uncertain whether CMS would accommodate late information from the April RUC meeting. Delaying publication of the revised codes is the surest way to avoid the possibility that inaccurate work RVUs are deployed in the 2022 fee schedule. Finally, we fully recognize that we may undertake this effort and still end up with similar results, but we believe the effort is worthwhile given our concerns with this initial survey data.

Recommendation

Therefore, for code 93654 the **societies recommend, <u>as an interim value</u>, the current work RVU of 19.75 with 63 minutes preservice time from package 4, 240 minutes intraservice time from the survey median, and 33 minutes postservice time from Post Service Package 9B**. This value builds some increment from 93653 that accounts for longer time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93654

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is about twice as likely as Medicare based claims.

Specialty Cardiac electrophysiology Frequency 11935 Percentage 77.00 %

Specialty Cardiology Frequency 3147 Percentage 20.30 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,750
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects 2019 eMedicare based claims.

Specialty Cardiac electrophysiology Frequency 5968 Percentage 77.00 %

Specialty Cardiology Frequency 1573 Percentage 20.29 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93654

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93655 Tracking Number Y3 Original Specialty Recommended RVU: **8.00**
Presented Recommended RVU: **8.00**
Global Period: ZZZ Current Work RVU: **7.50** RUC Recommended RVU: **6.50**

CPT Descriptor: Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia
(List separately in addition to code for primary procedure)
(Use 93655 in conjunction with 93653, 93654, 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old female has undergone successful ablation of her atrial supraventricular tachycardia (SVT) focus (reported separately). Attempts to re-induce that arrhythmia reveal an additional atrial focus (also reported separately). A decision is made to ablate this additional focus following its discovery.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: A full electrophysiologic study and ablation procedure has been performed. Diagnostic and ablative electrophysiology (EP) catheters are in cardiac chambers. During the course of the post-ablation electrophysiologic evaluation, a second (or greater) arrhythmia is identified. For example, if the primary tachycardia ablated was atrioventricular (AV) nodal reentrant tachycardia and during post ablation testing, an atrial tachycardia, atrial flutter, or accessory pathway with orthotropic reentry tachycardia is identified, this would be considered a separate mechanism of tachycardia. Pacing maneuvers are performed to define the mechanism(s) of the new tachycardia(s). Mapping is performed to define the optimal ablation site or sites that are distinct from the initial ablation site(s). Catheter ablation of this distinct mechanism of tachycardia is performed at its origin. Multiple lesions are delivered to ensure eradication of the arrhythmia focus and to provide consolidation lesions in the surrounding tissue.

During the course of an electrophysiology procedure, an arrhythmia is induced that requires use of advanced 3D computer-assisted mapping system to localize the arrhythmia origin. The mapping system is placed in the cardiac chamber of interest using standard percutaneous techniques. The system is calibrated, and recordings are made during sinus rhythm to identify normal activation and location of scar during each distinct tachycardia. The computer-generated map is displayed, modifications are made in the computer parameters and display, and the tachycardia origin is identified. The ablation catheter is moved to the point of early activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Additional mappings are made to confirm arrhythmia origin and to study additional arrhythmias at the conclusion of the procedure. A final report that includes the mapping procedure and findings is prepared.

To record left atrial activity, femoral venous access site is already prepared for related procedure. Achieve central venous access, place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access if that fails. Introduce the catheter into the sheath and advance into the right atrium where the ostium of the coronary sinus

is engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac electrophysiology procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report.

Throughout the ablation the patient is monitored for hemodynamic compromise due to cardiac perforation, - or tachyarrhythmias, embolic phenomena, or damage to cardiac or vascular structures. Following the ablation portion of the procedure, repeat electrophysiologic testing is performed to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. These are again repeated following a 30-minute waiting period following the conclusion of the final ablation lesion. If the tachycardia demonstrates recovery or incomplete suppression, then repeat mapping and ablation are performed as described above. These steps are repeated until the tachycardia is rendered durably suppressed.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93655					
Sample Size:	941	**Resp N:**	74			
Description of Sample:	randomly selected electrophysiologists from the two societies					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	10.00	**28.00**	50.00	300.00	
Survey RVW:	4.00	8.00	**10.00**	10.89	20.00	
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:	16.00	45.00	**60.00**	90.00	240.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93655	**Recommended Physician Work RVU: 6.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33257	ZZZ	9.64	**RUC Time**

CPT Descriptor Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93609	ZZZ	4.99	**RUC Time**

CPT Descriptor Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93592	ZZZ	8.00	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 17 **% of respondents:** 22.9 **%**

Number of respondents who choose 2nd Key Reference Code: 15 **% of respondents:** 20.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 93655	Top Key Reference CPT Code: 33257	2nd Key Reference CPT Code: **93609**
Median Pre-Service Time	0.00	15.00	0.00
Median Intra-Service Time	60.00	30.00	90.00
Median Immediate Post-service Time	0.00	15.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**60.00**	**90.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	24%	24%	52%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	24%	77%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	24%	76%
Physical effort required	0%	41%	59%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	29%	71%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	33%	40%	27%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	36%	74%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	40%	60%
Physical effort required	0%	40%	6000%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the

codes are re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: 93653 and 93656, and were tasked in surveying the other codes in the family: 93654, **93655,** and 93657.

The ACC and HRS randomly surveyed cardia electrophysiologists, as designated by membership rolls, on the newly created codes. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. This is the last of three new codes to report endovascular repair of aortic coarctation.

The key reference code is 33257 for operative tissue ablation and reconstructive of atria. It was selected by approximately 23% of respondents. 76% of the respondents indicated that 93655 was more complex. The second reference code was 93609 for intraventricular and/or intra-atrial mapping of tachycardia. It was selected by approximately 20% of respondents. About 67% of the respondents indicated that 93655 was more intense/complex overall.

Survey Concerns

In reviewing the survey data to develop work recommendations, the expert panel quickly developed doubts about the validity of the survey results for the newly bundled services, 93653 and 93656. In both instances, intraservice procedure times dropped significantly, despite the inclusion of the newly bundled elements. After deliberation, the expert panel concluded that we do not believe survey respondents thoroughly understood that 3D mapping and left atrial pacing were now inherent to 93653. This is despite language in the survey invitation and coding changes document (both attached).

We believe this may have occurred for two reasons. One is that despite providing information about the elements of the revised code, survey respondents still saw the same code number, 93653, and may have incorrectly believed the code descriptor was unchanged. The second reason is that when we compared the newly revised codes to code 93654 which did not undergo any revisions, that service came back with an identical intraservice procedure time and quite consistent work RVUs.

We can certainly think of reasons—mostly changes in technology and broader service dispersion—that intraservice times would decline somewhat after nearly a decade. However, the magnitude of the change does not comport with our professional experience. And these doubts are compounded by the absence of change in 93654, making us think something did not register for survey respondents.

Therefore, as part of this package of recommendations, we are also recommending the ultimate RUC value recommendations be made on an interim basis with a plan to resurvey these codes for the April RUC meeting. We have already developed several survey tool changes we for which we will seek Research Subcommittee approval, attempting to more actively prompt survey respondents to incorporate the new elements of the bundled service. One such tactic is to use a "dummy" code so they do not immediately perceive familiarity with the code descriptor. Another is to include a redline version of the code descriptor in the survey itself. Yet another is to more explicitly inform respondents in the invitation which elements have been bundled.

Since this is the last meeting of the 2022 CPT cycle, we have separately requested the CPT Editorial Panel withhold publication of these codes until 2023. (attached) We do not know the outcome of that request and are preparing to resurvey regardless. However, as noted in that letter, it is uncertain whether CMS would accommodate late information from the April RUC meeting. Delaying publication of the revised codes is the surest way to avoid the possibility that inaccurate work RVUs are deployed in the 2022 fee schedule. Finally, we fully recognize that we may undertake this effort and still end up with similar results, but we believe the effort is worthwhile given our concerns with this initial survey data.

Recommendation

While this code descriptor did not change, its use as an additional ablation with a new base code that includes 3D mapping and left-atrial pacing, changing the service. The same 3D mapping and left-atrial pacing elements that were bundled into 93653 should now typically be considered to be included into this service, since those elements occur throughout the additional ablation. Therefore, for code 93655 the **societies recommend, <u>on an interim basis,</u> the survey 25th-percentile RVW of 8.00 with 60 minutes intraservice time**. This is sensibly below the KRS, which is an open surgical procedure. This value also brings the IWPUT for 93655 in nearly identical alignment with that of 93653, as well as 93653 KRS 93580. This value can also be supported by comparison to another transcatheter cardiac service, 93592 that describes the work of placing an additional occlusion device to close a paravalvular leak.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93655

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 62294
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is about twice as likely as Medicare based claims.

Specialty Cardiac electrophysiology Frequency 50085 Percentage 80.40 %

Specialty Cardiology Frequency 10715 Percentage 17.20 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 31,821 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects Medicare based claims.

Specialty Cardiac electrophysiology Frequency 25042 Percentage 78.69 %

Specialty Cardiology Frequency 5474 Percentage 17.20 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93655

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93656 Tracking Number Y4 Original Specialty Recommended RVU: **24.20**
Presented Recommended RVU: **24.20**
Global Period: 000 Current Work RVU: **19.77** RUC Recommended RVU: **20.00**

CPT Descriptor: Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and his bundle recording, when performed
(Do not report 93656 in conjunction with 93279, 93280, 93281, 93282, 93283, 93284, 93286, 93287, 93288, 93289, 93462, 93600, 93602, 93603, 93610, 93612, 93613, 93618, 93619, 93620, 93621, 93653, 93654, 93662)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male with a history of hypertension has recurrent atrial fibrillation. despite rate and rhythm control with antiarrhythmic drugs, he remains symptomatic. a comprehensive electrophysiologic evaluation with transeptal catheterization and catheter ablation by pulmonary vein isolation for atrial fibrillation is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: A three-dimensional imaging study such as cardiac magnetic resonance imaging (MRI) or computed tomography (CT) scanning may be obtained prior to the procedure to assess atrial size and for pulmonary vein anatomic variants. The procedure and the risks, benefits, and alternatives associated with electrophysiology testing and atrial fibrillation ablation are explained to the patient and the patient's family. Management of antiarrhythmic medications is communicated to the patient. Arrangements are made for the X-ray technician, electrophysiology laboratory technician, and nurse. The patient is evaluated on the day of the procedure with a history and physical examination and pre-procedure laboratory, medications, and change in health status are reviewed with careful attention to the degree of anticoagulation. Informed consent is obtained.

Description of Intra-Service Work: Direct current cardioversion/defibrillation, electrophysiology (EP), and ablative equipment is confirmed to be present and in proper working order. Fluoroscopic equipment that will be used to visualize catheter movements and location is tested. Local analgesia is administered. Venous access is obtained. Arterial access to monitor blood pressure and to retrograde aortic access to the left ventricle may be obtained. By means of the venous access sites, multi-electrode catheters are positioned in specific cardiac chambers. An intracardiac echocardiographic probe is advanced into the heart and imaging of the heart and pericardium is performed: specific structures visualized include: right atrium, tricuspid valve, right ventricle, left atrium, aortic valve, left ventricle, pulmonary veins (left upper, left lower, right upper, right lower), pericardium, superior vena cava, coronary sinus. Intracardiac echocardiography may be used to guide catheter manipulation, guide transseptal puncture, provide visualization of catheter contact during mapping and ablation, and observe for complications throughout the procedure. The intracardiac echo catheter may be placed into the left atrium or right ventricle for additional imaging planes. One or two transseptal catheterizations are performed to achieve access and facilitate placement of both a circular mapping catheter and an ablation catheter in the left atrium.

Additional anticoagulation is administered. Level of anticoagulation is monitored throughout the procedure and additional anticoagulation is administered as needed. Conduction intervals and refractory periods are measured and arrhythmia induction attempted. His bundle recording and ventricular pacing and sensing are performed. A mapping catheter is passed into the left atrium and pulmonary vein conduction is assessed and recorded. Selective venography of the pulmonary veins may be performed to define anatomy. A high definition 3D anatomical map of the chamber(s) of interest is generated. Voltage and relative electrical activation in the arrhythmia and/or sinus may be performed to identify normal activation, location of scar, and mechanism of arrhythmia. Importation, segmentation, and/or registration to the three dimensional map of a MRI/CT scan may be performed. High output pacing is performed to prevent and/or monitor for phrenic nerve damage during ablation. Catheter ablation is then performed to achieve pulmonary vein isolation. Point lesions or balloon administered lesions encircling the pulmonary vein region are created that guided by anatomical mapping and electrical signals provided by a circular mapping catheter. Pulmonary vein isolation, as measured by the circular mapping catheter as well as loss of tissue voltage and tissue pacing capture are the measured endpoints.

During the course of an electrophysiology procedure, an arrhythmia is induced that requires use of advanced 3D computer-assisted mapping system to localize the arrhythmia origin. The mapping system is placed in the cardiac chamber of interest using standard percutaneous techniques. The system is calibrated, and recordings are made during sinus rhythm to identify normal activation and location of scar during each distinct tachycardia. The computer-generated map is displayed, modifications are made in the computer parameters and display, and the tachycardia origin is identified. The ablation catheter is moved to the point of early activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Additional mappings are made to confirm arrhythmia origin and to study additional arrhythmias at the conclusion of the procedure. A final report that includes the mapping procedure and findings is prepared.

Throughout the ablation the patient is monitored hemodynamic compromise due to cardiac perforation, - or tachyarrhythmias, embolic phenomena, thrombus formation, or damage to cardiac or vascular structures, including meticulous monitoring for lesion delivery within the pulmonary vein or close to the esophagus. Following the ablation portion of the procedure, further electrophysiologic testing is performed to assess the outcome of ablation. These are again repeated following a 30-minute waiting period following the conclusion of the final ablation lesion. If the pulmonary veins demonstrate recovery of conduction, then repeat mapping and ablation are performed as described above. These steps are repeated until the pulmonary veins are rendered durably isolated. Once electrophysiology testing and ablation are completed, anticoagulation is reversed. Post procedure, sheaths are removed, appropriate hemostasis is achieved, and follow-up assessment of the patient for any complications is performed.

Description of Post-Service Work: The patient is monitored in the recovery unit and then overnight in a telemetry unit for delayed complications. Results of the procedure are discussed with the patient and the patient's family and a postprocedure assessment is performed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93656					
Sample Size:	941	**Resp N:**	74			
Description of Sample:	randomly selected electrophysiologists from the two societies					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	38.00	**75.00**	108.00	300.00	
Survey RVW:	10.00	20.00	**24.20**	27.92	43.00	
Pre-Service Evaluation Time:			**50.00**			
Pre-Service Positioning Time:			**19.00**			
Pre-Service Scrub, Dress, Wait Time:			**20.00**			
Intra-Service Time:	60.00	180.00	**210.00**	240.00	360.00	
Immediate Post Service-Time:	**43.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	93656	**Recommended Physician Work RVU: 20.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**3.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**210.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**33.00**	**33.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93581	000	24.39	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 35.1 **%**

Number of respondents who choose 2nd Key Reference Code: 24 **% of respondents:** 32.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 93656	Top Key Reference CPT Code: 93580	2nd Key Reference CPT Code: **93581**
Median Pre-Service Time	63.00	30.00	40.00
Median Intra-Service Time	210.00	120.00	180.00
Median Immediate Post-service Time	33.00	60.00	60.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**306.00**	**210.00**	**280.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	8%	31%	62%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	12%	88%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	16%	84%
Physical effort required	0%	19%	81%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	8%	92%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	8%	38%	54%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	13%	83%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	13%	83%
Physical effort required	0%	35%	65%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	25%	75%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the

codes are re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: 93653 and **93656** and were tasked in surveying the other codes in the family: 93654, 93655, and 93657.

The ACC and HRS randomly surveyed cardia electrophysiologists, as designated by membership rolls, on the newly created codes. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. This is the last of three new codes to report endovascular repair of aortic coarctation.

The key reference code is 93580 for percutaneous transcatheter closure of a congenital interatrial communication. It was selected by approximately 36% of respondents. 92% of the respondents indicated that 93656 was more complex. The second reference code was 93581 for percutaneous transcatheter closure of a congenital ventricular septal defect with implant. It was selected by approximately 32% of respondents. About 92% of the respondents indicated that 93656 was more intense/complex overall.

Survey Concerns

In reviewing the survey data to develop work recommendations, the expert panel quickly developed doubts about the validity of the survey results for the newly bundled services, 93653 and 93656. In both instances, intraservice procedure times dropped significantly, despite the inclusion of the newly bundled elements. After deliberation, the expert panel concluded that we do not believe survey respondents thoroughly understood that 3D mapping and left atrial pacing were now inherent to 93653. This is despite language in the survey invitation and coding changes document (both attached).

We believe this may have occurred for two reasons. One is that despite providing information about the elements of the revised code, survey respondents still saw the same code number, 93653, and may have incorrectly believed the code descriptor was unchanged. The second reason is that when we compared the newly revised codes to code 93654 which did not undergo any revisions, that service came back with an identical intraservice procedure time and quite consistent work RVUs.

We can certainly think of reasons—mostly changes in technology and broader service dispersion—that intraservice times would decline somewhat after nearly a decade. However, the magnitude of the change does not comport with our professional experience. And these doubts are compounded by the absence of change in 93654, making us think something did not register for survey respondents.

Therefore, as part of this package of recommendations, we are also recommending the ultimate RUC value recommendations be made on an interim basis with a plan to resurvey these codes for the April RUC meeting. We have already developed several survey tool changes we for which we will seek Research Subcommittee approval, attempting to more actively prompt survey respondents to incorporate the new elements of the bundled service. One such tactic is to use a "dummy" code so they do not immediately perceive familiarity with the code descriptor. Another is to include a redline version of the code descriptor in the survey itself. Yet another is to more explicitly inform respondents in the invitation which elements have been bundled.

Since this is the last meeting of the 2022 CPT cycle, we have separately requested the CPT Editorial Panel withhold publication of these codes until 2023. (attached) We do not know the outcome of that request and are preparing to resurvey regardless. However, as noted in that letter, it is uncertain whether CMS would accommodate late information from the April RUC meeting. Delaying publication of the revised codes is the surest way to avoid the possibility that inaccurate work RVUs are deployed in the 2022 fee schedule. Finally, we fully recognize that we may undertake this effort and still end up with similar results, but we believe the effort is worthwhile given our concerns with this initial survey data.

Recommendation

Therefore, for code 93656 the **societies recommend, <u>on an interim basis</u>, the survey median RVW of 24.20 with 63 minutes preservice time from package 4, 210 minutes intraservice time from the survey median, and 33 minutes postservice time from package 9B**. These recommendations compare reasonably well with second KRS 93581 that has 30 minutes shorter intraservice time and 36 minutes shorter total time, though survey respondents who selected 93581 nearly universally said 93656 is more intense/complex. This recommendation also produces a work RVU savings from the current, component-coded services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93656

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 106654
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is about twice as likely as Medicare based claims.

Specialty Cardiac electrophysiology Frequency 92256 Percentage 86.50 %

Specialty Cardiology Frequency 13972 Percentage 13.10 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 53,327 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects Medicare based claims.

Specialty Cardiac electrophysiology Frequency 46128 Percentage 86.50 %

Specialty Cardiology Frequency 6986 Percentage 13.10 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93656

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93657 Tracking Number Y5 Original Specialty Recommended RVU: **8.00**
Presented Recommended RVU: **8.00**
Global Period: ZZZ Current Work RVU: **7.50** RUC Recommended RVU: **6.50**

CPT Descriptor: Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation
(List separately in addition to code for primary procedure)
(Use 93657 in conjunction with 93656)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old male has symptomatic atrial fibrillation refractory to medical therapy. An electrophysiology (EP) study and ablation are performed to achieve pulmonary vein isolation (reported separately). Despite demonstration of electrical isolation of the pulmonary veins, atrial fibrillation continues.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: A full electrophysiologic study and ablation procedure has been performed for atrial fibrillation. Diagnostic and ablation catheters are present in cardiac chambers. Pulmonary vein isolation has been accomplished. An intracardiac echocardiographic probe has been advanced into the heart and imaging of the heart and pericardium is performed. Intracardiac echocardiography may be used to guide catheter manipulation, guide transseptal puncture, guide catheter manipulation and observe for complications throughout the procedure. Due to the presence of non-pulmonary vein sources of atrial fibrillation, additional non-pulmonary vein ablation lesions are created. These additional ablation lesions may contain any or all of the following: 1) Regions of fractionated potentials are mapped and ablated outside the pulmonary vein area. 2) linear lesions are created along the roof, mitral isthmus, or septal aspect of the left atrium. 3) Non-pulmonary vein focal sources of atrial fibrillation induction are induced, localized, and ablated. These locations may include areas of the left atrium, right atrium, superior vena cava, or coronary sinus. During the delivery of ablation energy, continuous monitoring for hemodynamic instability, arrhythmias, embolic events, and injury to the esophagus is performed.

During the course of these additional ablation lesions, an advanced 3D computer-assisted mapping system is used to facilitate identification of sites to target for catheter ablation as well as to record sites of lesions to allow the operator to create linear lesions. The mapping system is placed in the cardiac chamber of interest using standard percutaneous techniques. The system is calibrated, and recordings are made during sinus rhythm to identify normal activation and location of scar during each distinct tachycardia. The computer-generated map is displayed, modifications are made in the computer parameters and display, and the tachycardia origin is identified. The ablation catheter is moved to the point of early activation, localized by the mapping system, to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, entrainment mapping studies are performed and evaluated to confirm the catheter location is within the reentrant circuit. Additional mappings are made to confirm arrhythmia origin and to study additional arrhythmias at the conclusion of the procedure. A final report that includes the mapping procedure and findings is prepared.

Appropriate post ablation attempts at reeducation and observation for 30-minutes are performed. Following restoration of sinus rhythm, conduction intervals are measured and arrhythmia induction is re-attempted over a 30-minute period following the last ablation lesion. If the target site demonstrates recovery or incomplete suppression, then repeat mapping and ablation are performed as described above. These steps are repeated until the target site is rendered durably suppressed or the line demonstrates durable conduction block.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2020					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Tuohy, MD; Mark Schoenfeld, MD; David Slotwiner, MD; Christopher Liu, MD					
Specialty Society(ies):	American College of Cardiology & Heart Rhythm Society					
CPT Code:	93657					
Sample Size:	941	**Resp N:**	74			
Description of Sample:	electrophysiologists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	10.00	**26.00**	50.00	150.00	
Survey RVW:	4.00	8.00	**9.05**	10.21	22.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	20.00	50.00	**60.00**	90.00	240.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93657	**Recommended Physician Work RVU: 6.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33257	ZZZ	9.64	**RUC Time**

CPT Descriptor Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33419	ZZZ	7.93	**RUC Time**

CPT Descriptor Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93592	ZZZ	8.00	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 22 **% of respondents:** 29.7 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 17.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 93657	Top Key Reference CPT Code: 33257	2nd Key Reference CPT Code: **33419**
Median Pre-Service Time	0.00	15.00	0.00
Median Intra-Service Time	60.00	30.00	90.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**45.00**	**90.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	5%	32%	18%	45%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	45%	55%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	32%	68%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	32%	59%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	39%	46%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	39%	46%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	46%	54%
Physical effort required	0%	58%	42%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	62%	30%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

History Background

When the Relativity Assessment Workgroup identified CPT code 93656 (atrial fibrillation ablation) due to its rapid increase in growth, the ACC and HRS reviewed the code and determined that certain work should be bundled into the existing code due to their being billed together more than 75% of the time. With continued review of 93656 and the related the volume data, the societies also identified that CPT 93653 (SVT ablation) should have services bundled into it before the

codes are re-surveyed for upcoming RUC valuation. As a result, in October 2020, the ACC and HRS presented a code change application to the CPT Editorial Panel on codes: 93653, 93654, 93655, 93656, **93657.**

The ACC and HRS randomly surveyed cardia electrophysiologists, as designated by membership rolls, on the newly created codes. The 000- and ZZZ-global day survey was completed by physicians who have experience with the service. This is the last of three new codes to report endovascular repair of aortic coarctation.

The key reference code is 33257 for operative tissue ablation and reconstruction of atria. It was selected by approximately 30% of respondents. 64% of the respondents indicated that 93657 was more complex. The second reference code was 33419 for transcatheter mitral valve repair. It was selected by approximately 18% of respondents. About 54% of the respondents indicated that 93657 was more intense/complex overall.

Survey Concerns

In reviewing the survey data to develop work recommendations, the expert panel quickly developed doubts about the validity of the survey results for the newly bundled services, 93653 and 93656. In both instances, intraservice procedure times dropped significantly, despite the inclusion of the newly bundled elements. After deliberation, the expert panel concluded that we do not believe survey respondents thoroughly understood that 3D mapping and left atrial pacing were now inherent to 93653. This is despite language in the survey invitation and coding changes document (both attached).

We believe this may have occurred for two reasons. One is that despite providing information about the elements of the revised code, survey respondents still saw the same code number, 93653, and may have incorrectly believed the code descriptor was unchanged. The second reason is that when we compared the newly revised codes to code 93654 which did not undergo any revisions, that service came back with an identical intraservice procedure time and quite consistent work RVUs.

We can certainly think of reasons—mostly changes in technology and broader service dispersion—that intraservice times would decline somewhat after nearly a decade. However, the magnitude of the change does not comport with our professional experience. And these doubts are compounded by the absence of change in 93654, making us think something did not register for survey respondents.

Therefore, as part of this package of recommendations, we are also recommending the ultimate RUC value recommendations be made on an interim basis with a plan to resurvey these codes for the April RUC meeting. We have already developed several survey tool changes we for which we will seek Research Subcommittee approval, attempting to more actively prompt survey respondents to incorporate the new elements of the bundled service. One such tactic is to use a "dummy" code so they do not immediately perceive familiarity with the code descriptor. Another is to include a redline version of the code descriptor in the survey itself. Yet another is to more explicitly inform respondents in the invitation which elements have been bundled.

Since this is the last meeting of the 2022 CPT cycle, we have separately requested the CPT Editorial Panel withhold publication of these codes until 2023. (attached) We do not know the outcome of that request and are preparing to resurvey regardless. However, as noted in that letter, it is uncertain whether CMS would accommodate late information from the April RUC meeting. Delaying publication of the revised codes is the surest way to avoid the possibility that inaccurate work RVUs are deployed in the 2022 fee schedule. Finally, we fully recognize that we may undertake this effort and still end up with similar results, but we believe the effort is worthwhile given our concerns with this initial survey data.

Recommendation

While this code descriptor did not change, its use as an additional ablation with a new base code that includes 3D mapping and intracardiac echo, changing the service. The same 3D mapping and intracardiac echo elements that were bundled into 93656 should now typically be considered to be included into this service, since those elements occur throughout the additional ablation. Therefore, for code 93657 the **societies recommend, <u>on an interim basis,</u> the survey 25th-percentile RVW of 8.00 with 60 minutes intraservice time**. This is sensibly below the KRS, which is an open surgical procedure. This value also brings the IWPUT for 93657 in near that of 93656, as well as 93656 KRS 93580. This value can also be supported by comparison to another transcatheter cardiac service, 93592 that describes the work of placing an additional occlusion device to close a paravalvular leak.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93657, 93613, 93662

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiac Electrophysiology How often? Commonly

Specialty Cardiology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 43919
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure is twice much as Medicare based claims.

Specialty Cardiac electrophysiology Frequency 36000 Percentage 81.96 %

Specialty Cardiology Frequency 8000 Percentage 18.21 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 21,959 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Figure reflects 2019e Medicare based claims.

Specialty Cardiac electrophysiology Frequency 18000 Percentage 81.97 %

Specialty Cardiology Frequency 4000 Percentage 18.21 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93657

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Cardiac Ablation Services Bundling
TAB: Tab 22

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93580	000	Percutaneous transcatheter closure of congenital interatrial	27	0.133	0.086			17.97			210	30					120			60					
2nd REF	33340	000	Percutaneous transcatheter closure of the left atrial	13	0.136	0.077			14.00			183	40	3	20			90			30					
CURRENT	93653	000	Comprehensive electrophysiologic evaluation		0.075	0.062			14.75			239	23	1	5			180			30					
CURRENT	93613	ZZZ	Intracardiac electrophysiologic 3-dimensional mapping (List		0.058	0.058			5.23			90						90								
CURRENT	93621	ZZZ	Comprehensive electrophysiologic evaluation		0.070	0.070			2.10			30						30								
SVY	93653	000	Comprehensive electrophysiologic evaluation	74	0.130	0.079	8.00	15.00	18.49	22.76	30.00	235	50	15	15	60	120	125	180	240	30	0	27	40	60	110
REC	93653	000	Comprehensive electrophysiologic evaluation		0.134	0.087			18.49			213	40	3	15			125			30					

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93581	000	Percutaneous transcatheter closure of a congenital	29	0.124	0.090			24.39			270	30					180			60					
2nd REF	93580	000	Percutaneous transcatheter closure of congenital interatrial	28	0.133	0.086			17.97			210	30					120			60					
CURRENT	93654	000	Comprehensive electrophysiologic evaluation		0.076	0.064			19.75			309	23	1	5			240			40					
SVY	93654	000	Comprehensive electrophysiologic evaluation	73	0.092	0.065	10.00	20.00	25.00	30.00	50.00	387	62	20	20	60	180	240	282	480	45	0	10	20	30	200
REC	93654	000	Comprehensive electrophysiologic evaluation		0.075	0.059			19.75			336	40	3	20			240			33					

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	33257	ZZZ	Operative tissue ablation and reconstruction of atria,	17	0.299	0.161			9.64			60	15					30			15					
2nd REF	93609	ZZZ	Intraventricular and/or intra-atrial mapping of tachycardia	15	0.055	0.055			4.99			90						90								
CURRENT	93655	ZZZ	Intracardiac catheter ablation of a discrete mechanism of		0.083	0.083			7.50			90						90								
SVY	93655	ZZZ	Intracardiac catheter ablation of a discrete mechanism of	74	0.167	0.167	4.00	8.00	10.00	10.89	20.00	60				16	45	60	90	240		0	10	28	50	300
REC	93655	ZZZ	Intracardiac catheter ablation of a discrete mechanism of		0.108	0.108			6.50			60						60								
Xwalk	34709	ZZZ	Placement of extension prosthesis(es) distal to the		0.108	0.108			6.50			60						60								
COMP	93592	ZZZ	Percutaneous transcatheter closure of paravalvular leak;		0.133	0.133			8.00			60						60								

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93580	000	Percutaneous transcatheter closure of congenital interatrial	26	0.133	0.086			17.97			210	30					120			60					
2nd REF	93581	000	Percutaneous transcatheter closure of a congenital	24	0.124	0.090			24.39			270	30					180			60					
CURRENT	93656	000	Comprehensive electrophysiologic evaluation		0.076	0.064			19.77			309	23	1	5			240			40					
CURRENT	93613	ZZZ	Intracardiac electrophysiologic 3-dimensional mapping (List		0.058	0.058			5.23			90						90								
CURRENT	93662	ZZZ	Intracardiac echocardiography during therapeutic/diagnostic		0.058	0.058			1.44			25						25								
SVY	93656	000	Comprehensive electrophysiologic evaluation	74	0.103	0.071	10.00	20.00	24.20	27.92	43.00	342	50	19	20	60	180	210	240	360	43	0	38	75	108	300
REC	93656	000	Comprehensive electrophysiologic evaluation		0.086	0.065			20.00			306	40	3	20			210			33					

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	33257	ZZZ	Operative tissue ablation and reconstruction of atria,	22	0.299	0.161			9.64			60	15					30			15					
2nd REF	33419	ZZZ	Transcatheter mitral valve repair, percutaneous approach,	13	0.088	0.088			7.93			90						90								
CURRENT	93657	ZZZ	Additional linear or focal intracardiac catheter ablation of		0.083	0.083			7.50			90						90								
SVY	93657	ZZZ	Additional linear or focal intracardiac catheter ablation of	74	0.151	0.151	4.00	8.00	9.05	10.21	22.00	60				20	50	60	90	240		0	10	28	50	300
REC	93657	ZZZ	Additional linear or focal intracardiac catheter ablation of		0.108	0.108			6.50			60						60								
Xwalk	34709	ZZZ	Placement of extension prosthesis(es) distal to the		0.108	0.108			6.50			60						60								
COMP	93592	ZZZ	Percutaneous transcatheter closure of paravalvular leak;		0.133	0.133			8.00			60						60								

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Outpatient Pulmonary Rehabilitation Services – Tab 23

In September 2020, the CPT Editorial Panel created two new codes to report physician or other qualified healthcare professional services for outpatient pulmonary rehabilitation, with and without continuous oximetry monitoring (per session). The specialty societies indicated they expect the two new codes to replace G0424 *Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day.*

Compelling Evidence
CMS HCPCS code G0424 *Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day* (work RVU = 0.28) was created in 2010, prior to publication of the detailed joint medical specialty Outpatient Pulmonary Rehabilitation (OPR) clinical guidelines in 2013. There is now a new definition of pulmonary rehabilitation, which states that pulmonary rehabilitation is a comprehensive intervention based on a thorough patient assessment, followed by patient tailored therapies that include but are not limited to exercise training, education and behavioral change to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health enhancing behaviors. Pulmonary Rehabilitation is now recognized as a core component of management of chronic obstructive pulmonary disease (COPD), and particularly focusing on health behavior change for this chronically ill population. However, patients with other advanced lung diseases can also participate in pulmonary rehabilitation.

In 2010, a survey was not conducted on the dominant performing specialty, Pulmonary Medicine. Therefore, the specialty societies presented, and the RUC agreed that compelling evidence is met due to incorrect assumptions/flawed methodology of the CMS/Other valuation, the code was not surveyed by pulmonary medicine physicians and the joint society clinical guidelines outline details were not captured nor valued in G0424. Additionally, there is documentation in peer-reviewed medical literature that there has been a change in the physician work due to both changes in technique, the updated guidelines and change in patient population to predominantly COPD patients.

94625 ***Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)***
The RUC reviewed the survey results of 39 pulmonologists and determined that the survey 25th percentile work RVU of 0.55 appropriately accounts for the work required to perform this service. The RUC recommends 2 minutes pre-service evaluation time, 9 minutes intra-service time and 10 minutes immediate post-service time. The RUC agreed with the specialty societies to decrease the intra-service time from the survey respondents' time of 15 minutes to 9 minutes.

The typical patient for 94625 is significantly more stable and less sick than the typical patient of 94626. The new CPT codes are different than G0424 as they are used per session and only once per day. The typical pulmonary rehabilitation program for a patient is a total of 36 sessions. CMS limits that to 72 sessions lifetime. These occur several days a week, typically two or three days per week spanning a total of two or three

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

months. The patients typically have sessions which last 90 minutes or more with exercise rotations each being 10 to 20 minutes each with time in between for an assessment of dyspnea as well as obtaining vital signs. The patients are in the office setting and are typically not in a group setting. The physician or qualified health provider is available and typically interacts with either the respiratory therapist (RT) or both the RT and the patient during and post- session. These patients typically need modifications to the plan to achieve success. The physician is not typically scheduled for other activities, such as Evaluation and Management (E/M) visits, while filling the role of the supervising physician. They may be performing administrative tasks or other non-face-to-face tasks but must be immediately available throughout the session.

In summary, the widely varying times that a physician participates in each session challenged the survey participants as it required them to consider the total times that are typical for all the sessions and then divide by the number of sessions to come up with a typical average session. Therefore, the specialty societies recommended revised times of 2 minutes pre-service evaluation time, 9 minutes intra-service time and 10 minutes immediate post-service time. The 9 minutes of intra-service time is the survey 25th percentile since this is clearly a more stable population than those receiving 94626 and would involve less physician involvement during their exercise period.

The RUC compared CPT code 94625 to the top key reference services, code 99497 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate* (work RVU = 1.50 and 30 minutes intra-service time) and 99238 *Hospital discharge day management; 30 minutes or less* (work RVU = 1.28 and 20 minutes of intra-service time). The RUC noted that the surveyed code requires much less physician time and work to perform, thus is appropriately valued lower.

For additional support, the RUC referenced MPC code 99407 *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes* (work RVU = 0.50 and 15 minutes total time) and code 99422 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes* (work RVU = 0.50 and 15 minutes total time), which require similar physician work and time. **The RUC recommends a work RVU of 0.55 for CPT code 94625.**

94626 *Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)*
The RUC reviewed the survey results of 39 pulmonologists and determined that the survey 25th percentile work RVU of 0.69 appropriately accounts for the work required to perform this service. The RUC recommends 2 minutes pre-service evaluation time, 14 minutes intra-service time and 10 minutes immediate post-service time.

The specialty society indicated that the patient population for 94626 will require oxygen at the onset. This is a patient population with advanced respiratory failure, who are already on oxygen, who will desaturate with exercise probably needing anywhere from four to six liters of oxygen per minute. These patients may have significant supraventricular arrhythmias, a-fibrillation with rapid ventricular response, non-sustained ventricular tachycardia or syncope in addition to their COPD exacerbations. Those are all significantly more likely and more common in the 94626 population, and much less common in the 94625 population, which is why the intra-service time is higher for 94626.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC compared CPT code 94626 to the top key reference service, code 94621 *Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings* (work RVU = 1.42, 30 minutes intra-service time and 50 minutes total time), noting that the surveyed code requires less physician work and time to perform. The RUC compared the surveyed code to the second top key reference code 99231 *Subsequent hospital care, per day…Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit* (work RVU = 0.76, 10 minutes of intra-service time and 20 minutes total time), noting both require similar physician work and time to perform.

For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70, 15 minutes intra-service time and 20 minutes total time) and code 94617 *Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)* (work RVU = 0.70, 10 minutes intra-service time and 26 minutes total time), which require almost identical physician work and time. **The RUC recommends a work RVU of 0.69 for CPT code 94626.**

CMS questioned and the specialty societies confirmed that any expected adverse reactions are included in the valuation for these codes since an E/M service would not be reported on the same date of service. Therefore, there will not be an issue if there are any edits to the E/M codes in the near future.

G Code Deletion
The RUC requests that CMS delete G0424, as these services could be reported by 94625 and 94626.

Practice Expense
The Practice Expense Subcommittee accepted the compelling evidence that the following have changed for these services: the dominant provider, the clinical guidelines, the technology/technique and patient population as outlined in the compelling evidence for work valuation above. The Practice Expense Subcommittee made a modification to the type of paper to SK057 *paper, laser printing (each sheet)*. The Subcommittee noted the specialties' use of L042B *Respiratory Therapist* for its clinical staff inputs. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Services
CPT codes 94625 and 94626 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine **Pulmonary** **Pulmonary Diagnostic Testing and Therapies**				
94621		*Cardiopulmonary exercise testing, including measurements of minute ventilation, CO_2 production, O_2 uptake, and electrocardiographic recordings* (Do not report 94617, *94619,* 94621 in conjunction with 93000, 93005, 93010, 93040, 93041, 93042 for ECG monitoring performed during the same session) (Do not report 94617, *94619,* 94621 in conjunction with 93015, 93016, 93017, 93018) (Do not report 94621 in conjunction with ~~*94250,*~~ 94680, 94681, 94690) (Do not report 94617, 94618, *94619,* 94621 in conjunction with 94760, 94761)		
Physician or Other Qualified Health Care Professional Services For Outpatient Pulmonary Rehabilitation				
~~G0424~~		~~Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day~~	~~XXX~~	~~N/A~~
●94625	Z1	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	XXX	0.55
●94626	Z2	with continuous oximetry monitoring (per session) (Do not report 94625, 94626 in conjunction with 94760, 94761)	XXX	0.69

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94625 Tracking Number Z1 Original Specialty Recommended RVU: **0.55**
Presented Recommended RVU: **0.55**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.55**

CPT Descriptor: Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old male with severe chronic obstructive pulmonary disease is enrolled in a pulmonary rehabilitation program without oximetry monitoring 45 days after hospitalization for an exacerbation.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician reviews the patient with COPD or other chronic respiratory disease with significant symptoms of dyspnea in the pulmonary rehabilitation facility. Initial evaluation of patient at the start of the rehabilitation program includes physician review of outside medical records, focusing on cardiopulmonary history and any limitations to exercise. This includes review of relevant comorbidities such as significant cardiac disease and review of prior cardiac testing (electrocardiogram, echocardiogram, or stress testing), cognitive impairment, or orthopedic/musculoskeletal/rheumatologic disorders or fall risk that may be limitations to exercise. The physician must also perform a detailed review of pulmonary history including prior diagnostic testing such as pulmonary function testing, 6-minute walk testing, imaging including chest x-rays or chest CT scans, medication regimen, and oxygen therapy. Initial evaluation would also include assessing symptoms with validated instruments such as the Modified Medical Research Council scale for dyspnea or the COPD Assessment Test and reviewing results with the patient. For subsequent visits, the physician reviews the patient's recent medical records including any new relevant cardiopulmonary diagnostic testing, if performed, and reviewing past pulmonary rehabilitation sessions as documented by the respiratory therapist.

Description of Intra-Service Work: A review of systems is performed and key information from the patient's medical records is reviewed and confirmed with the patient. The physician reviews the current vital signs including the SpO2 at rest and during exercise and compares them with previous readings. The physician decides whether the patient is fit to participate in the pulmonary rehabilitation program, and whether the patient will require monitoring during the exercise & strengthening portion of the program. The physician is required to be immediately available during the exercise session, and the physician will perform face-to-face evaluation of the patient for any acute issues arising including oxygen desaturations beyond baseline, tachypnea or respiratory distress, tachycardia, hypertension or hypotension, or symptoms of acute illness such as developing acute exacerbation of COPD.

Description of Post-Service Work: The physician reviews the progress of every patient regularly with the respiratory therapists or other staff, and the physician uses this information to update the individualized exercise prescription at least every 30 days, and confirm the patient is benefitting from the program and continues to be medically appropriate for rehabilitation. The physician will decide with the therapists which other elements the patient's individualized program should include, such as the decision to repeat or train on devices for inhaled medications or training on airway clearance. If acute issues required face-to-face evaluation in the intra-service time, then communication by phone and/or written report with the referring physician, primary care provider, or relevant specialists would be developed after the visit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021		
Presenter(s):	Amy Ahasic, MD, (CHEST), Katina Nicolacakis, MD (ATS), Robert DeMarco, MD (CHEST), Alan Plummer, MD, (ATS)		
Specialty Society(ies):	The American Thoracic Society (ATS) and The American College of Chest Physicians (CHEST)		
CPT Code:	94625		
Sample Size:	3003	**Resp N:**	39
Description of Sample:	Both ATS and CHEST surveyed all members of the pulmonary rehabilitation assemblies as well as random members from the general population.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**10.00**	40.00	550.00
Survey RVW:	0.20	0.55	**1.00**	1.20	20.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	9.00	**15.00**	30.00	45.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	94625	**Recommended Physician Work RVU: 0.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**9.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99497	XXX	1.50	**RUC Time**

CPT Descriptor Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99238	XXX	1.28	**RUC Time**

CPT Descriptor Hospital discharge day management; 30 minutes or less

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99407	XXX	0.50	**RUC Time**	83,194

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95251	XXX	0.70	**RUC Time**	248,288

CPT Descriptor 2 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
99422	XXX	0.50	**RUC Time**

CPT Descriptor Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 6 **% of respondents:** 15.3 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 94625	Top Key Reference CPT Code: 99497	2nd Key Reference CPT Code: **99238**
Median Pre-Service Time	2.00	5.00	8.00
Median Intra-Service Time	9.00	30.00	20.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**21.00**	**45.00**	**38.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	33%	50%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	83%	17%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	50%	50%
Physical effort required	17%	50%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	83%	17%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	20%	40%	20%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	60%	20%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	40%	40%
Physical effort required	20%	80%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	20%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The AMA CPT panel created two new codes for outpatient pulmonary (OPR) rehabilitation services at the September 2020 CPT meeting. One code describes when pulse oximetry is performed during the session, 94626, while the other CPT code describes the same service without monitoring of pulse oximetry, 94625. The CPT panel approved the same vignette for each service, this recognizes that the same patient can have the OPR services at a site of their choice, based on the

protocols of the different rehabilitation facility (following the society guidelines), the resources of oximetry can be identified and tracked with the reporting of one of the two new CPT codes. Of note, CMS created G0424 in 2010, 10+ years ago. However, there are differences in the G code description as well as the development of detailed OPR guidelines from the medical specialties. The societies believe these are new codes and services not previously described.

Compelling Evidence, if required:

Since the G0424 codes does exist with utilization, we are also providing our compelling evidence arguments in case the RUC feels it necessary. In short, the G code was created prior to publication of the detailed joint medical specialty OPR guidelines in 2013 and updated. No RUC survey was performed by the dominant performing specialty, Pulmonary Medicine, therefore we believe we meet the two below RUC compelling evidence arguments, as the G code is a CMS/Other values code not surveyed by pulmonary medicine physicians and the joint society guidelines outline details not captured nor valued in the G code.

"Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

- a flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values or CMS/Other source codes;

Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:

- knowledge"

Survey Results & ATS/CHEST Recommendations:
94625

A joint ATS and CHEST RVS panel (ATS/CHEST) reviewed and discussed the survey results. The ATS/CHEST panel was pleased that there were 39 responses to the survey request. This service is provided by subgroups of our larger medical specialties. The survey performance rate median of 10 studies per year among the 39 respondents is an understandable rate given this is a low volume service among our varying membership. The sample drawn from our memberships included all members of the pulmonary rehabilitation assemblies if available from each society, and a random pull of the general membership. These two groups were loaded into Qualtrics and then 90% of that group were surveyed to produce the required RUC random component to the survey pool. Surveying only members of the assemblies would not have given us enough of a pool to reach the required completed surveys. We did extend the survey past our original close date by 6 days and send urgent reminders to those surveyed, stating that we had not yet reached the required minimum, in order to finally reach the RUC minimum. We did receive more than usual number of responses that resources were limited due to COVID surges. In the end we were pleased on our revised deadline to have obtained 39 completed surveys.

Time Discussion:
The ATS/CHEST panel reviewed and discussed at length the pre, intra and post service survey median times of 10, 15 and 10 minutes. The discussion revolved around how to account for the significant times that are not typical in all sessions but are typical for the first session or any subsequent session(s) when the patient has an event or set back requiring re-evaluation and changes to the OPR plan for that patient. It was noted that these patients are of our sicker population as evidenced that our survey patient vignette was typical 82% of the time. Physicians are always on site and available to the respiratory therapist during each session. We would point out that they are not present at each patient session, however there is discussion with the therapist post each session. The first few sessions are time intensive for the physician as they develop and refine the session program for the Respiratory Therapist to follow. The RVS panel experts stated that often these initial and reevaluation can take upwards of 1 to 2 hours. It also was noted by the experts who run these programs that intervention most often occurs as post work to the session. While only the initial is frontloaded with pre time. Therefore, the expert panel considered that 60 minutes divided by 36 sessions would amount to 2 minutes of pre time for each session. The expert panel believes that the survey respondents had a difficult time defining how much time to allocate to the pre and the post for this reason, the expert panel believes an adjustment of the pre time is necessary and is recommending a pre time of 2 minutes as calculated and stated above.

In summary, the widely varying times that a physician participates in each session challenged the survey participant, as well as the experts, to consider the total times that are typical for all the sessions and then divide by the number of

sessions to come up with a typical average session. We believe our expert panel understood this best and therefore are recommending a revised survey time of 2 minutes of pre time, with the 25th percentage of 9 minutes (after discussion with facilitation) of intra time and 10 minutes of post time for each session.

Work Discussion:
We compared 94625 to the reference code CPT 99497 (*Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) RVW 1.50 (5-30-10);* while we believe these procedures are comparable, we believe the work for 94625 would require less time and less work than 99497. The ATS/CHEST panel also compared 94625 to the second key reference code CPT 99238 (*Hospital discharge day management; 30 minutes or less) with an RVW of 1.28 (8-20-10)* and believes this procedure's work and times would be higher and require more time than the survey code.

In summary, we are recommending an RVW of 0.55 for 94625 which is our 25th percentile survey, with a pre-service time 2 minutes, intra-service time 9 minutes and post-service time 10 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0424

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonary Medicne How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Neurology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 23223
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare utilization of G0424 divided by the two codes, multipled by 3.

Specialty Pulmonary Medicine Frequency 13005 Percentage 56.00 %

Specialty Internal Medicine Frequency 3716 Percentage 16.00 %

Specialty Neurology Frequency 1393 Percentage 5.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,741
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare Utilization of G0424 divided by the two codes from the RUC data base.

Specialty Pulmonary Medicine Frequency 4335 Percentage 56.00 %

Specialty Internal Medicine Frequency 1239 Percentage 16.00 %

Specialty Neurology Frequency 464 Percentage 5.99 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. G0424

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94626 Tracking Number Z2 Original Specialty Recommended RVU: **0.69**
Presented Recommended RVU: **0.69**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.69**

CPT Descriptor: Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session) / (do not report 94625, 94626 in conjunction with 94760, 94761).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: a 67-year-old male with severe chronic obstructive pulmonary disease is enrolled in a pulmonary rehabilitation program with oximetry monitoring 45 days after hospitalization for an exacerbation.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: TThe physician reviews the patient with respiratory failure due to COPD or other chronic respiratory disease with significant symptoms of dyspnea in the pulmonary rehabilitation facility. Initial evaluation of patient at the start of the rehabilitation program includes physician review of outside medical records, focusing on cardiopulmonary history and any limitations to exercise. This includes review of relevant comorbidities such as significant cardiac disease and review of prior cardiac testing (electrocardiogram, echocardiogram, or stress testing), cognitive impairment, or orthopedic/musculoskeletal/rheumatologic disorders or fall risk that may be limitations to exercise. The physician must also perform a detailed review of pulmonary history including prior diagnostic testing such as pulmonary function testing, 6-minute walk testing, imaging including chest x-rays or chest CT scans, medication regimen, and oxygen therapy. Initial evaluation would also include assessing symptoms with validated instruments such as the Modified Medical Research Council scale for dyspnea or the COPD Assessment Test and reviewing results with the patient. For subsequent visits, the physician reviews the patient's recent medical records including any new relevant cardiopulmonary diagnostic testing , if performed, and pulse oximetry tracings from prior sessions along with reviewing past pulmonary rehabilitation sessions as documented by the respiratory therapist.

Description of Intra-Service Work: A review of systems is performed and key information from the patient's medical records is reviewed and confirmed with the patient. The physician reviews the current vital signs including the SpO2 at rest and during exercise, and compares them with previous readings. The physician decides whether or not the patient is fit to participate in the pulmonary rehabilitation program, and whether the patient will require supplemental oxygen (determine the amount of oxygen) and monitoring during the exercise & strengthening portion of the program. The physician is required to be immediately available during the exercise session, and the physician will perform face-to-face evaluation of the patient for any acute issues arising including oxygen desaturations beyond baseline or despite supplemental oxygen, tachypnea or respiratory distress, tachycardia, hypertension or hypotension, or symptoms of acute illness such as developing acute exacerbation of COPD.

Description of Post-Service Work: The physician reviews the progress of every patient regularly with the respiratory therapists or other staff, and the physician uses this information to update the individualized exercise prescription at least every 30 days, and confirm the patient is benefitting from the program and continues to be medically appropriate for rehabilitation. The physician will decide with the therapists which other elements the patient's individualized program should include, such as the decision to repeat or train on devices for inhaled medications or training on airway clearance as

well as the oxygen level required during exercise. If acute issues required face-to-face evaluation in the intra-service time, then communication by phone and/or written report with the referring physician, primary care provider, or relevant specialists would be developed after the visit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Amy Ahasic, MD, (CHEST), Katina Nicolacakis, MD (ATS), Robert DeMarco, MD (CHEST), Alan Plummer, MD, (ATS)					
Specialty Society(ies):	The American Thoracic Society (ATS) and The American College of Chest Physicians (CHEST)					
CPT Code:	94626					
Sample Size:	3003	**Resp N:**	39			
Description of Sample:	Both ATS and CHEST surveyed all members of the pulmonary rehabilitation assemblies as well as random members from the general population.					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**8.00**	33.00	400.00
Survey RVW:		0.35	0.69	**1.09**	1.53	75.00
Pre-Service Evaluation Time:				**10.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		1.00	9.00	**14.00**	21.00	50.00
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	94626	**Recommended Physician Work RVU: 0.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**2.00**	**0.00**	**2.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**14.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
94621	XXX	1.42	**RUC Time**

CPT Descriptor Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99231	XXX	0.76	**RUC Time**

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99407	XXX	0.50	**RUC Time**	83,194

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95251	XXX	0.70	**RUC Time**	248,288

CPT Descriptor 2 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
94617	XXX	0.70	**RUC Time**

CPT Descriptor Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 6 **% of respondents:** 15.3 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 12.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 94626	Top Key Reference CPT Code: 94621	2nd Key Reference CPT Code: **99231**
Median Pre-Service Time	2.00	10.00	5.00
Median Intra-Service Time	14.00	30.00	10.00
Median Immediate Post-service Time	10.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**26.00**	**50.00**	**20.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	17%	50%	33%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	0%	80%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	40%	60%
Physical effort required	20%	20%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	17%	83%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	40%	20%	0%	40%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	40%	0%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	40%	40%
Physical effort required	20%	40%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	40%	0%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The AMA CPT panel created two new codes for outpatient pulmonary (OPR) rehabilitation services at the September 2020 CPT meeting. One code describes when pulse oximetry is performed during the session, 94626, while the other CPT code describes the same service without monitoring of pulse oximetry, 94625. The CPT panel approved the same vignette for each service, this recognizes that the same patient can have the OPR services at a site of their choice, based on the protocols of the different rehabilitation facility (following the society guidelines), the resources of oximetry can be identified and tracked with the reporting of one of the two new CPT codes. Of note, CMS created G0424 in 2010, 10+ years ago. However, there are differences in the G code description as well as the development of detailed OPR guidelines from the medical specialties. The societies believe these are new codes and services not previously described.

Compelling Evidence, if required:

Since the G0424 codes does exist with utilization, we are also providing our compelling evidence arguments in case the RUC feels it necessary. In short, the G code was created prior to publication of the detailed joint medical specialty OPR guidelines in 2013 and updated. No RUC survey was performed by the dominant performing specialty, Pulmonary Medicine, therefore we believe we meet the two below RUC compelling evidence arguments, as the G code is a CMS/Other values code not surveyed by pulmonary medicine physicians and the joint society guidelines outline details not captured nor valued in the G code.

"Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

- a flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values or **CMS/Other source codes**;

Documentation in the **peer-reviewed medical literature** or other reliable data that there have been changes in physician work due to one or more of the following:

- **knowledge**"

Survey Results & ATS/CHEST Recommendations:
94626

A joint ATS and CHEST RVS panel (ATS/CHEST) reviewed and discussed the survey results. The ATS/CHEST panel was pleased that there were 39 responses to the survey request. This service is provided by subgroups of our larger medical specialties. The survey performance rate median of 8 studies per year among the 39 respondents is an understandable rate given this is a low volume service among our varying membership. The sample drawn from our memberships included all members of the pulmonary rehabilitation assemblies if available from each society, and a random pull of the general membership. These two groups were loaded into Qualtrics and then 90% of that group were surveyed to produce the required RUC random component to the survey pool. Surveying only members of the assemblies would not have given us enough of a pool to reach the required completed surveys. We did extend the survey past our original close date by 6 days and send urgent reminders to those surveyed, stating that we had not yet reached the required minimum, in order to finally reach the RUC minimum. We did receive more than usual number of responses that resources were limited due to COVID surges. In the end we were pleased on our revised deadline to have obtained 39 completed surveys.

Time Discussion:

The ATS/CHEST panel reviewed and discussed at length the pre, intra and post service survey median times of 10, 14 and 10 minutes. The time discussion was the same as 94625 with the exception that it was unfortunate that the intra time came out different at 14 minutes. The expert panel stated they would have expected a minute or two more or at minimum the same 15 minutes of intra time. This presented an awkward situation as the standard is to accept the median times from the survey. The panel did review the data from the surveys from only those that completed both CPT codes. This sub analysis is provided for your information in the RUC excel summary and it does support our expert's opinion regarding the intra time relationships for each CPT code. However, we are not clear if the RUC would allow changing the times to a sub analysis. Therefore, we are recommending the total survey intra times.

In summary, the widely varying times that a physician participates in each session challenged the survey participant, as well as the experts, to consider the total times that are typical for all the sessions and then divide by the number of sessions to come up with a typical average session. We believe our expert panel understood this best and therefore are

recommending a revised survey time of 2 minutes of pre time, with the medians of 14 minutes of intra time and 10 minutes of post time for each session.

Work Discussion:

We compared 94625 to the reference code CPT 94621 *(Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings) RVW 1.42 (10-30-10);* while we believe these procedures are comparable, we believe the work for 94625 would require less time and less work than 94621. The ATS/CHEST panel also compared 94625 to the second key reference code CPT 99231 (*Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.) with an RVW of 0.76 (5-10-5)* and believes this procedure's work total times and RVW are more comparable and somewhat higher than the survey code.

In summary, to maintain rank order we are recommending an RVW of 0.69 for 94626 which is our 25th percentile survey, with a pre-service time 2 minutes, intra-service time 14 minutes and post-service time 10 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G0424

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pulmonary Medicine How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Neurology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 23223
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare for G0424 code times 3.

Specialty Pulmonary Medicine Frequency 13005 Percentage 56.00 %

Specialty Internal Medicine Frequency 3716 Percentage 16.00 %

Specialty Neurology Frequency 1393 Percentage 5.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,741
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare for G0424 from RUC data base

Specialty Pulmonary Medicine Frequency 4335 Percentage 56.00 %

Specialty Internal Medicine Frequency 1239 Percentage 16.00 %

Specialty Neurology Frequency 464 Percentage 5.99 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. G0424

CHAPTER

3

Exercise Assessment and Training

Chris Garvey, FNP, MSN, MPA, MAACVPR
University of California and San Francisco Medical Center

Rebecca Crouch, PT, DPT, MS, CCS, MAACVPR
Campbell University and Duke Hospital
Durham, NC

David Verrill, MS, CEP, RCEP, FAACVPR
University of North Carolina at Charlotte

Exercise is well established as the cornerstone of pulmonary rehabilitation in persons with chronic lung disease due to its capacity to improve exercise tolerance in people with chronic lung disease (1). Exercise intolerance is multifactorial, resulting from progressive skeletal muscle dysfunction, disabling dyspnea and fatigue, comorbidities, mood disorders, hypoxemia, and in persons with chronic obstructive pulmonary disease (COPD), hyperinflation. Although the majority of evidence for effectiveness of exercise is derived from studies in persons with COPD, growing evidence supports the effectiveness of exercise as part of pulmonary rehabilitation in other lung diseases. The general principles of exercise training in persons with chronic lung disease are the same as for healthy individuals, and are individualized based on history and physical examination, clinical assessment, and objective and subjective findings. To optimize effectiveness, the training load must exceed that normally encountered in daily life to improve fitness and muscle strength (i.e., the training threshold). Exercise levels should progress throughout pulmonary rehabilitation based on ongoing comprehensive assessment. A key focus of exercise in pulmonary rehabilitation is long-term behavior change to achieve ongoing participation in physical activity and exercise. Several adjuncts have the potential to improve exercise in appropriate patients, including bronchodilation, oxygen, breathing techniques such as pursed-lip breathing, one-leg exercise, and use of rollators (rolling walkers). Critical areas of investigation include technology-supported and home- or community-based exercise (1).

RATIONALE FOR EXERCISE TRAINING IN CHRONIC LUNG DISEASE

Many factors must be considered when selecting an exercise plan for persons with lung disease. To achieve the greatest benefit from exercise training, the rehabilitation team works closely with

574-76386_ch03_1P.indd 21 30/11/18 10:20 PM

the physician to achieve optimization of medical therapy, including appropriate use of medications and oxygen. Successful rehabilitation outcomes depend on effective communication and a coordinated team effort to identify and meet the patient's medical, functional, and psychological needs. The patient and the family are at the center of educational interventions that focus on adaptation and behavior change (see chapter 4).

Exercise training is the cornerstone of pulmonary rehabilitation. Virtually all patients with chronic respiratory disease have strong potential to benefit from exercise training (1, 2). Patients whose physical limitations permit them to exercise at higher intensities can achieve significant improvement in aerobic conditioning, while those with more severe limitations can improve with lower-intensity endurance training (3). While aerobic and resistance upper-body exercise training is essential for all appropriate patients, resistance exercise training has been shown to be essential to improve upper- and lower-body strength and muscle volume, activities of daily living (ADL) performance and health-related quality of life (3–10). The evidence base supporting the functional benefits of both short- and long-term exercise training in COPD is among the strongest in pulmonary medicine (1, 2, 11). While more research is needed on the effect of aerobic and resistance exercise training in patients with other chronic lung diseases, including restrictive and interstitial lung diseases such as pulmonary fibrosis, recent trials have shown positive results (1, 12–15). A warm-up period should be included in each exercise session to provide gradual increases in heart rate (HR), blood pressure, ventilation, and blood flow to the exercising muscles. A cool-down reduces the risk of arrhythmias, orthostatic hypotension, syncopal episodes, and bronchospasm (16, 17).

MECHANISMS OF EXERCISE INTOLERANCE IN CHRONIC RESPIRATORY DISEASE

Respiratory and nonrespiratory factors, alone or in combination, can significantly decrease the exercise tolerance of persons with chronic lung disease (1, 18–22). Although cardiopulmonary abnormalities are generally considered of fundamental importance, skeletal muscle dysfunction has been increasingly recognized as a key factor that contributes to exercise intolerance (18). Perception of leg effort or discomfort is the main symptom limiting exercise in 40 to 45% of patients with COPD (21). Skeletal muscle dysfunction in COPD is characterized by reductions in muscle mass and strength; atrophy of slow-twitch, oxidative endurance muscle fibers; and reductions in fiber capillarization, oxidative enzyme capacity, and muscle endurance (18). Both resting and exercise muscle metabolism are impaired, with lower exercise tolerance and lactic acidosis occurring at lower exercise workloads compared to healthy persons (18, 21, 23). Systemic inflammation, nutrition impairment, aging, low anabolic hormone levels, corticosteroid-related myopathy, frailty, and hypoxia further contribute to skeletal muscle dysfunction in COPD (23, 24).

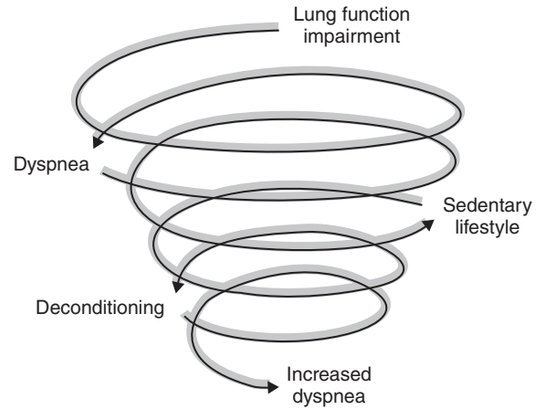


Figure 3.1 Dyspnea spiral.

Reprinted, by permission, from C. Prefaunt, A. Varray, and G. Vallet, "Pathophysiology Basis of Exercise Training in Patients With Chronic Obstructive Lung Disease," *European Respiratory Review* 5, no. 25 (1995): 27–32.

Complicating all of these disease effects is physical deconditioning. This is a consequence of patients assuming an increasingly sedentary lifestyle to avoid the unpleasant sensation of dyspnea. Inactivity in turn leads to further deconditioning and increased exertional dyspnea, creating the dyspnea spiral depicted in figure 3.1.

EXERCISE ASSESSMENT

Prior to exercise assessment, pulmonary rehabilitation providers should carefully review the patient history and physical examination with a focus on disorders that may potentially worsen or become unstable during exercise, including:

-1—
0—
+1—

574-76386_ch03_1P.indd 22 30/11/18 10:20 PM

- History of cardiovascular disease (coronary artery disease; previous myocardial infarction; chest pain; arrhythmia; new onset, untreated, uncontrolled, or chronic atrial fibrillation with resting rate >110 bpm; ventricular tachycardia; second- or third-degree atrioventricular block; T wave inversion or ST elevation)
- Moderate to severe valve disease
- Symptomatic or new onset heart failure
- Large patent foramen ovale causing shunt physiology

Additional disorders and comorbidities such as significant cognitive, severe psychiatric abnormalities, and intractable pain should be reviewed by the medical director with communication to the referring clinician or specialist to determine the patient's appropriateness as a pulmonary rehabilitation candidate.

Used with permission from University of California San Francisco, C. Garvey and N. Gidwani.

Purposes of the Exercise Assessment for Patients with Chronic Lung Disease

- Quantify exercise capacity before beginning a program (25, 26)
- Evaluate unexplained dyspnea and exercise intolerance (27, 28)
- Observe for abnormal signs and symptoms of exercise intolerance (25–27)
- Establish a baseline for outcome documentation (28)
- Help establish patient-specific goals (29)
- Prognostic evaluation for patient risk stratification (24, 25)
- Drug treatment efficacy evaluation
- Exercise evaluation for research purposes (26)
- Evaluation of patient impairment and disability for insurance purposes and workman's compensation
- Assist in formulating an exercise prescription for exercise training (3, 16, 27, 28)
- Detect exercise-induced hypoxemia and aid with titrating supplemental oxygen therapy (30, 31)
- Evaluate nonpulmonary limitations to exercise (e.g., musculoskeletal problems) (23, 24, 32, 33)
- Help to detect underlying cardiac abnormalities and coronary artery disease (16, 26, 27)
- Help to evaluate status of congestive heart failure (if present)
- Screen for exercise-induced bronchospasm (34)
- Evaluation for heart, lung, or heart/lung transplant (26, 27)

For most respiratory patients *without* known or suspected cardiac problems, exercise testing, even to maximal levels, is relatively safe. Contraindications to exercise testing in this setting are relatively few. Standard lists of absolute and relative contraindications are concerned primarily with patients with known or suspected cardiovascular.

General safety considerations when performing exercise testing are as follows (26, 29, 34):

- All test administrators must be trained and competent in performing cardiopulmonary resuscitation.
- Oxygen and emergency equipment should be in close proximity to the testing site.
- If testing is not performed in a hospital environment, adequate emergency procedures must be in place.
- If the patient has been prescribed long-term oxygen therapy, the exercise test should usually be carried out using the prescribed level of oxygen. An exception might be the evaluation of a patient who may no longer need supplemental oxygen. If significant hypoxemia is present during activity, consider titrating the patient during ambulation prior to exercise testing.
- At a minimum, continuous pulse oximetry should be used to measure (SpO_2) and HR to monitor the patient's physiological response to exercise.
- Validated dyspnea and exertion scales should be used to measure the patient's perceived shortness of breath and effort during the test (e.g., Borg category-ratio or Borg perceived exertion chart).

FIELD TESTS (WALKING TESTS)

Field (walking) tests are commonly used for measurement of functional capacity in the pulmonary rehabilitation setting. Advantages include

—-1
—0
—+1

that the tests are functional, generally safe and easy to perform, inexpensive, and do not require extensive or expensive equipment. These tests are easily administered in the majority of pulmonary rehabilitation patients, including those that are debilitated. However, the test does not offer comprehensive physiological monitoring.

Six-Minute Walk Test

The 6-minute walk test (6MWT) is a widely used outcome measure for pulmonary rehabilitation (34–37). The test is safe, easy to administer, involves the use of minimal technical resources, is well tolerated, and accurately reflects a familiar activity of daily living (walking). The 6MWT measures the maximum distance walked in 6 minutes. To obtain valid and reliable results, it is essential to standardize the test procedure, such as staff, configuration of track, patient instructions and verbal reinforcement during testing, type, use and flow rate of supplemental oxygen, and walking aids (35).

One must consider the energy expenditure changes that occur while performing the 6MWT under certain circumstances, such as while using an assistive walking aid (e.g., rollator) and when a supplemental oxygen source is placed on the walking aid. It has been suggested that there are a reduction of breathlessness and an improvement in the distance walked when using a walking aid or supplemental oxygen (35). One study found as much as a 20 to 25% energy cost savings with the addition of a walking aid that supported supplemental oxygen. These energy savings appear to be most notable in persons with COPD who have lower exercise performance; e.g., 6MWT distance of <300 meters (38). Consequently, if a walking aid is used on the first test, or a required supplemental oxygen source is carried on the walker, the same walking preparation must be used with subsequent testing.

Directions on performing the 6MWT are given below.

Before the Test

- Standardize the shape of the flat walking course: straight versus continuous circle, oval, or square. If using a corridor, a minimum of 30 meters (98.4 feet) that is free of traffic and obstacles should be used.
- A comfortable ambient temperature and humidity should be maintained for all tests.
- A medical history for the patient has been reviewed and any precautions or contraindications to exercise testing have been taken into account (see absolute and relative contraindications, figures 3.4 and 3.5 later in the chapter).
- Instruct the patient to dress comfortably, wear appropriate footwear, and avoid eating or drinking for at least 2 hours before the test (when possible or appropriate).
- Prescribed inhaled bronchodilator medications should be taken if ordered within 1 hour of testing or when the patient arrives for testing.
- Rest for at least 10 minutes before beginning the test. If two tests are performed on the same day, at least 30 minutes rest should be allowed between tests.
- Record blood pressure BP, HR, SpO_2, and dyspnea score while the patient is sitting or standing. Measure HR and SpO_2 continuously during the test.
- Describe the walking track to the patient and give the patient standardized instructions (35) (see table 4.1).
- If the patient has not performed a 6MWT in the recent past, two tests should be performed for initial testing due to a significant learning effect. Use the greater of the two test results (35).

During the Test

The patient should be asked to walk as far as he or she can in 6 minutes. Standardized encouragement and notification of time elapsed should be given at specific intervals according to the European Respiratory Society (ERS)/American Thoracic Society (ATS) 6MWT script (35) (see table 3.1). Rests are allowed and included in the total test time. If the patient stops during the test (once SpO_2 is ≥85%), advise the patient every 30 seconds to "please resume walking whenever you feel able" (35).

- The total distance covered is recorded.
- The patient is asked to rate shortness of breath and effort using a validated dyspnea and fatigue scale.
- The patient should walk alone; staff, other patients, or family should not walk with the patient performing the test. If necessary to

-1—
0—
+1—

Table 3.1 Script for Standardized Encouragement for 6-Minute Walk Test

1 minute	You are doing well. You have five minutes to go.
2 minutes	Keep up the good work. You have four minutes to go.
3 minutes	You are doing well. You are halfway.
4 minutes	Keep up the good work. You have only two minutes left.
5 minutes	You are doing well. You have only one minute to go.
6 minutes	Please stop where you are.
If the patient stops during the test, every 30 seconds (once SpO_2 is ≥85%)	Please resume walking whenever you feel able.

Key: SpO_2 = arterial oxygen saturation measured by pulse oximetry

Reproduced with permission of the © ERS 2018: *European Respiratory Journal* Jun 2004, 23 (6) 832–840; DOI: 10.1183/09031936.04.00116004.

have staff close to the patient during the walk for safety, they should walk behind the patient.

- Oxygen flow should be held constant during any test; oxygen titration should not be performed during a measured distance outcome walk test. Subsequent tests should use the same flow rate and modality if possible and safe.
- Staff should not assist the patient in carrying or pulling supplemental oxygen unless the patient cannot safely maneuver oxygen.
- Count laps with a lap counter.
- The patient may use their usual ambulatory assistive device; make note of which device (e.g., single-point cane, rollator walker, standard walker) is used and why.
- Monitor the patient for untoward signs and symptoms, including continuous SpO_2 and HR.
- The oximeter should not be held by the patient. Either a finger oximeter or a handheld oximeter in a pouch should be used.

Ending the Test

- Once the 6 minutes are completed, the patient is instructed to stop where he or she is.
- Note if the patient exhibits any untoward signs and symptoms.
- Stop the test for:
  - SpO_2 desaturation <80%
  - Chest pain
  - Intolerable dyspnea
  - Intolerable leg cramps, signs of intolerance to exercise exertion such as staggering, or unusual diaphoresis
  - Pale or ashen appearance
- Immediately record SpO_2, HR, dyspnea, fatigue, and blood pressure while patient is sitting (measurements taken before and after the test should be done with the patient in the same position).
- Record the distance completed in feet or meters, number of rest stops, total time of stops, and final vital signs including the lowest SpO_2 level (and oxygen flow rate if used) on a standardized recording form (35, 39).

Figure 3.2 shows a sample evaluation form for use in the 6MWT. The MET level corresponding to the average walking speed can be estimated based on the distance walked in 6 minutes. One MET is the amount of energy required while the body is at rest. This may be useful information for assessing exercise capacity and formulating an initial exercise prescription (see figure 3.3). Other information can be gleaned from the test, including gait analysis, balance, fatigue, and pain assessment.

The 6MWT can be influenced by multiple factors, including motivation, encouragement, learning effect, physical course layout, testing environment, gender, and age. Standardized encouragement must be given. There is a learning effect in performing successive 6MWTs, and distances may increase by 26.3 meters on subsequent tests, therefore two

—-1
—0
—+1

Figure 3.2 Pulmonary rehabilitation 6-minute walk test evaluation form*

	Initial 6-minute walk				Discharge 6-minute walk		
Parameters	**Pre-walk**	**Walk 1**	**MPH**	**Meters / minute**	**Walk 1**	**MPH**	**Meters / minute**
Total distance (m or ft)							
# of rests							
Time of rest, sec							
Validated dyspnea scale							
$SpO_{2,}$ %							
$F_IO_{2,}$ %							
$O_{2,}$ L/min							
BP, mmHg							
HR, bpm							
METs							
Patient symptoms (see key)							
Walking devices used (see key)							
Other comments							
Staff initials							
Date							

Key: MPH = miles per hour.

Patient symptoms = chest pain, dizziness, shortness of breath, leg pain, cramps, etc.
Walking devices used = walker (type), cane, etc.
*Note that two walks are advised if the patient has not recently performed a 6MWT.

Staff signature:_____

574-76386_ch03_1P.indd 26 30/11/18 10:20 PM

Figure 3.3 Calculating MET levels from the 6-minute walk test

A MET is a metabolic equivalence of a task or a unit for expressing energy expenditure. One MET is the level of energy expenditure (oxygen consumption) at rest at approximately 3.5 ml O_2/kg/min (2). Activities can be expressed as requiring a multiple of resting requirements. Formulas are available to estimate energy cost (METs) of various activities, such as walking. MET levels during walking may be calculated by using the following formula (1 ml O_2/kg/min of $\dot{V}O_2$ is required for 10 m/min of walking):

METs = [baseline MET + walk MET] / baseline MET

Example: 100 meters walked in a 6-minute walk

METS = [3.5 + (100 m/6 min) × (min/10 m)] / 3.5 = 1.47

An alternative approach (ACSM formula for estimating $\dot{V}O_2$ [METs] for horizontal walking) (16, 37):

$\dot{V}O_2$ (METs) = [3.5ml/kg/min + (0.1 × ___speed (m/min)]/3.5ml/kg/min

Expressing walking distance as average walking speed in miles per hour (e.g., feet/sec × 0.68) or 6MWD (feet) × 10 / 5280 =____mph

METs can be calculated from speed in mph:

METs = [(___mph)(26.83m/min) × (0.1ml/kg/min) + 3.5ml/kg/min]

walks should be performed during the initial testing, using the furthest distance of the two tests (35–36). If two tests are performed, the recommendation is to wait at least 30 minutes, or up to the next day, to repeat the second test and that the greater of the two values be reported (34–37).

The use of a treadmill for 6MWT is not advised (35, 36, 39). The physical layout of the course may impact walking distance. In the National Emphysema Treatment Trial (NETT), centers that used continuous walking courses, either oval or square, reported longer 6MWT distances than those with straight courses. The difference attributable to the course layout was 110 feet (33.5 meters), or a 10% advantage for continuous courses (40). The difference between straight and continuous courses may be due to the time and effort required for the subject to turn around on a straight course. The preassessments and postassessments in pulmonary rehabilitation, therefore, must use the same course to eliminate this potential variability.

Prediction formulas for the 6MWT distance are available. This information can be used to assess the patient's level of impairment, compared to data from healthy adults (36, 39, 41). If using a prediction formula, the formula should be derived populations similar to the pulmonary rehabilitation program population. The minimal clinically meaningful change or minimum clinically important difference (MCID) in the 6MWT distance has been reported to be a mean of 30 meters (98.4 feet) (35). For those patients who walk a very short distance in their initial 6MWT (<200 meters, or <656 feet), an additional strategy has been suggested to help evaluate improvement which involves calculating the percent (%) change in pre—versus post–pulmonary rehabilitation walk distance (feet or meters) (34).

Shuttle Walk Tests

There are two types of shuttle walk tests: the incremental and the endurance shuttle walk tests. The ISWT is an incremental, symptom-limited walk test that simulates a symptom-limited cardiopulmonary exercise test (CPET). It measures a symptom-limited walking distance over a marked walking course of 10 meters (33 feet). This distance correlates well with maximal oxygen uptake (42). The ISWT utilizes an audible pacing timer to incrementally increase the pacing frequency (table 3.2). The subject walks according to the pacing timer frequency until they are too breathless to continue or cannot keep pace with the external pacing signal. Like the 6MWT, the primary test result of the ISWT is the total distance walked. As with the 6MWT, the ISWT should be performed twice prior to an intervention, with the best result

574-76386_ch03_1P.indd 27 30/11/18 10:20 PM

Table 3.2 Example of Layout and Pacing Algorithm for Shuttle Walk Distance Test

Level	Speed m/s	Number of shuttles per level	Distance ambulated at the end of each level (m)
1	0.50	3	30
2	0.67	4	70
3	0.84	5	120
4	1.01	6	180
5	1.18	7	250
6	1.35	8	330
7	1.52	9	420
8	1.69	10	520
9	1.86	11	630
10	2.03	12	750
11	2.20	13	880
12	2.37	14	1020

Reprinted by permission S.J. Singh et al., "Development of a Shuttle Walking Test of Disability in Patients With Chronic Airways Obstruction," *Thorax* 47 (1992): 1019–1024.

recorded (41). The patient should rest for 30 minutes between tests. Directions for performing the ISWT are given below.

The endurance shuttle test (ESWT) is a standardized, externally controlled, constant-paced walking test for the assessment of endurance capacity. The ISWT is initially performed to determine exercise capacity, and then a paced walk speed corresponding to 85% of walking speed on the ISWT is used to determine the walking speed for the ESWT (42, 43). The ESWT is a field test equivalent of the constant workload test. The primary outcome of the ISWT is distance, measured to the nearest 10 meters, whereas the primary outcome of the ESWT is time, consistent with other endurance tests (35–37).

Since exercise endurance improves more than peak oxygen concentration (peak $\dot{V}O_2$) after pulmonary rehabilitation exercise training, the ESWT is more responsive to pulmonary rehabilitation than the ISWT (28, 35–36). For the ISWT, a change of distance of 47.5 meters has been described as associated with feeling "slightly better," while a change of 78.7 meters has been associated with feeling "better"; therefore, the MCID for the ISWT distance in COPD is 47.5 meters (35). Preliminary data suggests the MID for the ESWT is in the region of 180 seconds (35).

Before the Test

- A medical history for the patient has been reviewed and any precautions or contraindications to exercise testing have been taken into account.
- Instruct the patient to dress comfortably, wear appropriate footwear, and avoid eating or drinking for at least 2 hours before the test (when possible or appropriate).
- Prescribed inhaled bronchodilator medications should be taken if ordered within 1 hour of testing or when the patient arrives for testing.
- Two cones are set 9 meters apart. The distance walked around the cones is 10 meters.
- The patient should rest for at least 15 minutes before beginning the test.
- Record blood pressure, HR, SpO_2, and dyspnea score while the patient is sitting or standing.

-1—
0—
+1—

During the Test

- Standardized instructions should be used via an audio recording.
- No encouragement should be given throughout the test.
- Record each shuttle that is completed on the recording sheet.
- The subject is asked to rate dyspnea and effort using a validated scale.
- The patient should walk alone; staff, other patients, or family should not walk with the patient performing the test.
- Do not assist the patient in carrying or pulling his/her supplemental oxygen.
- The patient may use an ambulatory assistive device; make note of which device (e.g., single-point cane, rollator, standard walker) is used and why.
- A comfortable ambient temperature and humidity should be maintained for all tests.
- Monitor the patient for untoward signs and symptoms.
- Stop the test for:
  - Chest pain suspicious of angina.
  - Evolving mental confusion or lack of coordination.
  - Evolving light-headedness.
  - Intolerable dyspnea.
  - Leg cramps or extreme leg muscle fatigue.
  - Persistent $SpO_2 \leq 85\%$.
  - Any other clinically warranted reason.

Ending the Test

- The patient is more than 0.5 meter (1.6 feet) away from the cone when the beep sounds (allow one lap to catch up).
- The patient determines that he or she is too breathless to continue.
- For the endurance shuttle walk test (ESWT): The patient reaches 85% of predicted maximum HR.
- The patient exhibits any untoward signs and symptoms.
- Immediately record SpO_2, HR, and dyspnea rating while the patient is sitting or standing (measurements taken before and after the test should be done with the patient in the same position).
- Two minutes later, record SpO_2 and HR to assess the recovery rate.
- Record the total number of shuttles completed.
- Record the reason for terminating the test.

Adapted from C. Garvey, *AACVPR Pulmonary Rehabilitation Outcome Toolkit,* https://www.aacvpr.org/Member-Center/Pulmonary-Rehab-Outcomes-Resource-Guide 2017.

Proponents argue that, when compared to a self-paced 6MWT, the shuttle tests are less influenced by motivation or pacing, correlate better with exercise capacity in patients with chronic lung disease, and may be a more sensitive indicator of functional change with rehabilitation or other therapies (35). Performance on the ISWT relates strongly to direct measures of peak $\dot{V}O_2$, allowing the prediction of peak $\dot{V}O_2$ (41). During the ISWT, the cardiorespiratory response to exercise (peak $\dot{V}O_2$) develops in an incremental fashion similar to formal CPET, thus making this a simple test requiring less technical expertise and equipment (35, 42). Furthermore, the ISWT is easier to administer, is less expensive, and incorporates an activity that patients perform on a daily basis (i.e., walking).

GRADED EXERCISE TEST AND CARDIOPULMONARY EXERCISE TESTS

Clinical exercise testing, often described as a graded exercise test (GXT), may additionally include expired gas or metabolic analysis. It is then often described as a cardiopulmonary exercise test (CPET) and provides important clinical information for the pulmonary rehabilitation practitioner. The rationale for performing the GXT is patient-specific (see "Purposes of the Exercise Assessment for Patients with Chronic Lung Disease"). Exercise limitations during the GXT or CPET may be due to various causes. Ventilatory requirements during graded exercise are often higher than expected in patients with chronic lung disease due to the increased work of breathing, increased dead space ventilation, earlier onset of lactic acidosis, respiratory muscle dysfunction, impaired gas exchange (hypoxia), increased ventilatory demand due to deconditioning, and peripheral muscle dysfunction (e.g., lower limb dysfunction) (1).

Maximal exercise tolerance is typically measured with a GXT performed on either a treadmill or stationary cycle ergometer in the laboratory

—-1
—0
—+1

(1, 16, 25, 26). In most clinical circumstances, cycle ergometry using an electronically braked ergometer is the preferred mode of exercise. However, a treadmill may be an acceptable alternative depending upon the purpose of the test. Arm ergometry may be substituted for those patients who are unable to perform lower-extremity exercises, although arm ergometer tests traditionally produce a lower $\dot{V}O_{2peak}$ (16, 25, 44). The GXT can be performed with either a ramped test or incremental increases in exercise load (e.g., 15 to 25 watts/minute on a cycle or arm ergometer) using a variety of established protocols until the patient reaches a symptom-limited maximal level of exertion. Physiologic responses to graded exercise that are commonly evaluated during the GXT include HR, ECG, blood pressure (BP), SpO_2, arterial blood analysis via arterial line on selected pulmonary patients, and ratings of perceived exertion and dyspnea. Symptoms of dyspnea can be rated by using the Borg category-ratio (CR10) dyspnea scale or a visual analog scale (VAS). With the addition of expired gas analysis for CPET, it is possible to evaluate parameters such as $\dot{V}O_2$, carbon dioxide production, and ventilatory threshold. Figure 3.4 provides a few of the parameters that can be assessed and analyzed during the CPET (27, 44). The addition of arterial blood gas analysis allows for the most accurate assessment of arterial oxygenation (e.g., alveolar–arterial oxygen gradient, oxygen partial pressure, PaO_2), carbon dioxide (CO_2) levels, dead space/tidal volume ratio (V_D/V_T), and acid-base balance measurements. CPET provides the most robust method for exercise evaluation in chronic lung disease, but due to its complexity and expense, widespread use may be limited in many pulmonary rehabilitation programs.

Contraindications for Graded Exercise Testing

For most respiratory patients without known or suspected cardiac problems, exercise testing to even maximal levels is relatively safe. Regular 12-lead electrocardiographic graded exercise test (GXT), incremental maximal exercise testing (IMET), and cardiopulmonary exercise testing (CPET) in the medically supervised setting have been shown to be very safe when performed by physicians or specially trained health professionals (45).

Figure 3.4 Common metabolic parameters assessed with cardiopulmonary exercise testing

- $\dot{V}O_2$ (mL/kg/min and L/min)
- % predicted peak $\dot{V}O_2$
- Peak $\dot{V}O_2$ uptake (mL/kg/min)
- First and second ventilatory thresholds (VT, mL/kg/min)
- Workload at the first and second VT
- % predicted VT
- Heart rate (HR) and heart rate reserve (HRR)
- Ventilatory reserve (VR)
- Respiratory exchange ratio (RER)
- Oxygen pulse (mL O_2 /kg/beat)
- Minute or pulmonary ventilation (V_E)
- Tidal volume (TV)
- Respiratory rate (f, breaths/minute)
- V_E/VCO_2 and V_E/O_2 (ventilatory equivalents) slopes, presented as ventilation/volume of expired carbon dioxide or oxygen
- Fraction of inspired oxygen (F_IO_2)
- Fraction of expired carbon dioxide (F_ECO_2)
- Partial pressure of end-tidal carbon dioxide ($P_{ET}CO_2$)
- Exercise oscillatory ventilation
- Circulatory power (CircPw, mmHg/mL/kg/min)
- End-tidal PCO_2 and PaO_2 (e.g., from arterial blood gas measurements)
- Physiologic dead space-to-tidal volume ratio (V_D/V_T)
- $P_{ET}O_2$

Common contraindications and precautions for CPET and GXT have been presented by the American Thoracic Society (ATS) and American College of Chest Physicians (ACCP) (26), as well as the American Heart Association (AHA) and American College of Sports Medicine (ACSM) (16, 44). While these two sets of guidelines are quite similar, there are subtle differences that the pulmonary

-1—
0—
+1—

574-76386_ch03_1P.indd 30 30/11/18 10:20 PM

Figure 3.5 ATS/ACCP absolute and relative contraindications for cardiopulmonary exercise testing including ISWT.

Absolute

- Acute myocardial infarction (3–5 days)
- Unstable angina
- Uncontrolled arrhythmias causing symptoms or hemodynamic compromise
- Syncope
- Active endocarditis
- Acute myocarditis or pericarditis
- Symptomatic severe aortic stenosis
- Uncontrolled heart failure
- Acute pulmonary embolus or pulmonary infarction
- Thrombosis of lower extremities suspected dissecting aneurysm
- Uncontrolled asthma
- Pulmonary edema
- Room air desaturation at rest ≤85%*
- Respiratory failure
- Acute noncardiopulmonary disorder that may affect exercise performance or be aggravated by exercise (i.e., infection, renal failure, thyrotoxicosis)
- Mental impairment leading to inability to cooperate

Relative

- Left main coronary stenosis or its equivalent
- Moderate stenotic valvular heart disease
- Severe untreated arterial hypertension at rest (>200 mmHg systolic, >120 mm Hg diastolic)
- Tachyarrhythmias or bradyarrhythmias
- High-degree atrioventricular block
- Hypertrophic cardiomyopathy
- Significant pulmonary hypertension
- Advanced or complicated pregnancy
- Electrolyte abnormalities
- Orthopedic impairment that compromises exercise performance

*Exercise patient with supplemental O_2.

Reprinted from American Thoracic Society/American College of Chest Physicians. ATS/ACCP Statement on Cardiopulmonary Exercise Testing," *American Journal of Respiratory Critical Care Medicine* 167 (2003); 211–277.

rehabilitation practitioner needs to consider. Figures 3.5 and 3.6 present common precautions and contraindications to consider prior to performing symptom- or sign-limited submaximal and maximal GXT or CPET for patients with chronic pulmonary disease.

It should be noted that in patients with primary pulmonary arterial hypertension (PAH) and moderate to severe pulmonary hypertension (PH), pulmonary artery pressure often increases with exercise and there is an increased risk of sudden death. Although caution is advised when testing patients with PAH, CPET can be performed safely in both pediatric and adult populations when prescribed by a clinician with expertise in care of PH patients (46, 47, 48). It is ultimately up to the patient's pulmonologist or clinic supervising physician to determine which patients with PH are suitable for CPET. More research is required to ascertain the risks and benefits of testing those with severe PAH and moderate to severe PH in the clinical setting.

It is also vitally important to terminate the GXT or CPET at the appropriate endpoints. Figures 3.7 and 3.8 present common criteria for terminating the symptom- or sign-limited maximal graded exercise test. Two sets of criteria are presented—those from the ATS/ACCP (26) and those from the AHA, American College of Cardiology (ACC) and ACSM (16, 25, 44). The second set of criteria is divided into both absolute and relative indications for exercise test termination.

It is vitally important that all applicable safety precautions are set in place prior to any form of exercise testing. General safety considerations for cardiopulmonary exercise testing are presented in figure 3.9 (29, 49).

In pulmonary patients, two other assessments should also be considered during the GXT. First,

—-1
—0
—+1

Figure 3.6 AHA and ACSM absolute and relative contraindications to symptom-limited graded exercise testing

Absolute

- Acute myocardial infarction within 2 days
- Ongoing unstable angina
- Uncontrolled cardiac arrhythmia with hemodynamic compromise
- Active endocarditis
- Symptomatic severe aortic stenosis
- Decompensated heart failure
- Acute pulmonary embolism, pulmonary infarction or deep vein thrombosis
- Acute myocarditis or pericarditis
- Acute aortic dissection
- Physical disability that precludes safe and adequate exercise testing

Relative

- Known obstructive left main coronary artery stenosis
- Moderate to severe aortic stenosis with uncertain relationship to symptoms
- Tachyarrhythmia with uncontrolled ventricular rates
- Acquired advanced or complete heart block
- Recent stroke or transient ischemic attack
- Mental impairment with limited ability to cooperate
- Resting hypertension with systolic >200 mmHg or diastolic >110 mmHg
- Uncorrected medical complications, such as significant anemia, important electrolyte imbalance, and hypothyroidism

Reprinted with permission from the American College of Sports Medicine, *ACSM's Guidelines for Exercise Testing and Prescription*, 10th ed. (Philadelphia: Wolters/Kluwer—Lippincott Williams & Wilkins, 2018), 118.

Figure 3.7 ATS/ACCP indications for exercise test termination

- Chest pain suggestive of ischemia
- Ischemic ECG changes
- Complex ectopy
- Second- or third-degree heart block
- Fall in systolic pressure of 20 mmHg from the highest value during the test
- Hypertension (250 mmHg systolic; 120 mm Hg diastolic)
- Severe desaturation: $SpO_2 \leq 80\%$ when accompanied by symptoms and signs of severe hypoxemia
- Sudden pallor
- Loss of coordination
- Mental confusion
- Dizziness or faintness
- Signs of respiratory failure
- Definition of abbreviations: ECG = electrocardiogram; SpO_2 = arterial oxygen saturation measured by pulse oximetry

Adapted from. American Thoracic Society/American College of Chest Physicians. "ATS/ACCP Statement on Cardiopulmonary Exercise Testing," *American Journal of Respiratory Critical Care Medicine*167 (2003): 211–277.

dynamic hyperinflation can develop with increasing ventilation; this can be assessed periodically with maximal flow-volume loops and measurements of inspiratory capacity (3). Second, exercise-induced bronchospasm can be assessed by spirometry for up to 30 minutes postexercise (33). Commonly used criteria to define specific limitations during exercise testing are given in figure 3.10 (29).

FUNCTIONAL PERFORMANCE ASSESSMENT

In addition to formal exercise testing, patients should be assessed by questioning and physical assessment regarding functional performance status. This should include evaluation of respiratory muscle function, breathing mechanics, and thoracic mobility (e.g., diaphragmatic excursion, accessory breathing patterns, and rib cage flexibility). Equally important is the evaluation of balance, fall risk, and any orthopedic or musculoskeletal limitations; for example, the patient's gait

-1—
0—
+1—

Figure 3.8 AHA/ACC/ACSM indications for terminating a symptom-limited maximal exercise test

Absolute

- ST elevation (>10 mm) in leads without preexisting Q waves because of prior MI (other than aVR, aVL, or V_1)
- Drop in systolic blood pressure of >10 mmHg, despite an increase in workload, when accompanied by other evidence of ischemia
- Moderate to severe angina
- Central nervous symptoms (e.g., ataxia, dizziness, or near syncope)
- Signs of poor perfusion (cyanosis or pallor)
- Sustained ventricular tachycardia or other arrhythmia, including second- or third-degree atrioventricular block that interferes with normal maintenance of cardiac output during exercise
- Technical difficulties monitoring the ECG or systolic blood pressure
- The subject's request to stop

Relative

- Marked ST displacement (horizontal or downsloping of >2 mm, measured 60 to 80 ms after the J point in a patient with suspected ischemia)
- Drop in systolic blood pressure >10 mmHg (persistently below baseline) despite an increase in workload, in the absence of other evidence of ischemia
- Increasing chest pain
- Fatigue, shortness of breath, wheezing, leg cramps, or claudication
- Arrhythmias other than sustained ventricular tachycardia, including multifocal ectopy, ventricular triplets, supraventricular tachycardia, and bradyarrhythmia that have the potential to become more complex to interfere with hemodynamic stability
- Exaggerated hypertensive response (systolic blood pressure >250 mm Hg or diastolic blood pressure >115 mmHg)
- Development of bundle-branch block that cannot be distinguished from ventricular tachycardia
- $SpO_2 \leq 80\%$

Key: ECG = electrocardiogram; MI = myocardial infarction; SpO_2 = arterial oxygen saturation measured by pulse oximetry

Reprinted with permission. Modified from: Fletcher GF, Balady G, Froelicher VF, Hartley LH, Haskell WL, Pollock ML. Exercise standards: a statement for healthcare professionals from the American Heart Association Writing Group: special report. *Circulation* 1995; 91:580–615. ©1995 American Heart Association, Inc.

should be evaluated for abnormalities that may require individualized alterations to the exercise plan and ambulatory assistive devices. Figure 3.11 outlines some of the important considerations in this assessment (23).

Musculoskeletal problems are especially prominent in the pulmonary rehabilitation population. (1, 17, 18, 21). It is important to make a thorough assessment of the patient's baseline levels of strength, range of motion, posture, orthopedic limitations, and simple ADL (e.g., lying to standing, dressing, climbing steps).

EXERCISE PRESCRIPTION

Exercise prescription requires understanding the principles of exercise training, exercise mode, frequency, and duration. Additionally, exercise progression is an important concept used in prescribing exercise.

Principles of Exercise Training

Many factors must be considered when selecting an optimal exercise plan for persons with respiratory disease. To gain the most benefit from exercise training, it is imperative that the rehabilitation team work closely with the physician to achieve optimization of medical therapy, including the use of oxygen for treatment of hypoxemia. Successful rehabilitation outcomes depend on communication and a coordinated effort of the team to identify and meet the patient's medical and functional needs.

Exercise training in pulmonary rehabilitation should encompass upper- and lower-extremity

—-1
—0
—+1

Figure 3.9 General safety considerations when performing exercise testing for pulmonary patients (29, 49)

- All test administrators must be trained in cardiopulmonary resuscitation and demonstrate competency in use of exercise prescription in chronic lung disease.
- Oxygen and emergency equipment should be in close proximity to the testing site.
- If testing is not performed in a hospital environment, adequate emergency procedures and equipment must be in place.
- If the patient is using long-term ambulatory oxygen therapy, the exercise test should usually be carried out using the prescribed level of oxygen. An exception might be the evaluation of a patient who may no longer need supplemental oxygen.
- At a minimum, pulse oximetry should be used to measure HR and SpO_2 to monitor the patient's physiological response to exercise. Dyspnea and established exertion scales should be used to measure the patient's perceived effort and shortness of breath and effort during the test.

Figure 3.10 Criteria for determining limitations during a symptom-limited graded exercise test

Ventilatory Limits

- Maximal exercise V_E /MVV >80%
- Rising P_aCO_2
- Rising V_D/V_T
- Development of dynamic hyperinflation
- Development of exercise-induced bronchospasm

Gas Exchange Limits

- Falling S_aO_2 or S_pO_2

Cardiovascular Limits

- Exercise HR >80% age-predicted maximal HR
- Falling blood pressure
- Serious dysrhythmia
- Cardiac symptoms (e.g., chest pain)
- Hypertensive or hypotensive response
- Deconditioning

Other Limits

- Orthopedic
- Peripheral vascular
- Musculoskeletal
- Metabolic
- Motivational or psychological

endurance training, strength training, and possibly respiratory muscle training. Frequency, intensity, time (duration), type (mode), volume, pattern, and progression of exercise should be included in each patient's initial treatment plan (ITP) as part of the exercise prescription. These components should be based upon the patient's disease severity, degree of conditioning, functional evaluation, and initial exercise testing data.

The FITT Principles of Aerobic Exercise Prescription for Pulmonary Patients

The ACSM (16) developed the FITT (Frequency, Intensity, Time, Type, Volume, Pattern, and Progression) technique from evidence-based guidelines for exercise prescription in both apparently healthy and some diseased populations. For patients with chronic lung disease, evidence supports aerobic exercise recommendations for those with COPD (1, 2, 16, 50–52) (table 3.3).

Specific evidence-based exercise training guidelines for patients with asthma are not currently available. However, exercise training is normally well tolerated in asthmatics who are successfully managed with proper pharmacotherapy (53). Position statements on exercise in those with asthma (54) and systematic reviews of this topic (54) support the ACSM FITT principles for exercise for asthmatics (16, 55) (table 3.4).

-1—
0—
+1—

574-76386_ch03_1P.indd 34 30/11/18 10:20 PM

Figure 3.11 Functional Status Assessment Considerations

- Muscle strength and endurance
- Joint range of motion limitations
- Postural abnormalities (e.g., kyphosis, scoliosis, rounded or elevated shoulders)
- Oxygen equipment (e.g., type, weight and mobility of device)
- Subjective endurance and work tolerance
- Prior level of function
- Dyspnea
- Level of understanding of fitness and exercise
- Fear of exertion
- Ability to pace activities and energy conservation
- Balance abnormalities, gait instability, or increased risk of falling
- Pain levels and locations
- Ability to perform household chores (e.g., vacuuming, laundry, cooking)
- Ability to groom oneself (e.g., showering, dressing)
- Ability to move around home (e.g., climb stairs, walk to bathroom)

Exercise Type (Mode)

It is most beneficial to direct exercise training to those muscles involved in functional daily living. This typically includes training the muscles of both the upper and lower extremities to improve cardiovascular endurance, muscular strength and endurance, and range of motion. Exercise training of the lower extremities often results in dramatic increases in exercise tolerance of patients with COPD (1–3, 52, 60–65, 67, 79–81) and other respiratory diseases (12–15, 82). Exercises that improve neuromotor abilities, such as balance and coordination to decrease fall risk, are equally important with the pulmonary population (23, 29, 74, 83–85). This topic is explored further later in this chapter.

The mode of exercise will vary by the available equipment and space available at the pulmonary rehabilitation facility. Indoor track or treadmill walking is a common mode of lower-body exercise training for most pulmonary rehabilitation programs and may be the most beneficial type of exercise, as walking requires total body movement. For those who can walk, it is recommended to be included in their pulmonary rehabilitation exercise training program and can help contribute to overall functional gains for most people (training specificity). Other aerobic exercise modalities include cycle ergometers (both upright and recumbent), arm ergometers, rowing machines, step machines, recumbent cross-training devices, seated and upright elliptical trainers and use of one-legged training (see table 3.5). Water exercise is ideal for those with arthritic or musculoskeletal abnormalities due to the lack of stress on the joints and overall body conditioning. Nordic walking is another promising option for walking in persons with chronic lung disease (1).

Frequency and Duration

In general, the frequency and duration of medically supervised pulmonary rehabilitation exercise may vary from three to five times per week (1–3, 16, 34, 63, 64), 20 to 90 minutes per session (2, 16, 34, 68), and extend over a period of 8 to 12 weeks (1–3, 52, 65–69). Eight to 12 weeks of pulmonary rehabilitation produces benefits in several outcome areas that eventually decline over 12 to 24 months (52, 69). While there remains no general consensus of opinion on the optimal duration of pulmonary rehabilitation, the duration should be adequate to provide maximal individualized benefits without becoming burdensome. Although research has shown inconsistent findings of the overall benefits of long-term pulmonary rehabilitation maintenance programs of up to 3 years in duration (69–75), longer duration programs (e.g., beyond 12 weeks), may produce greater sustained benefits than shorter-term programs (52, 69–70, 75–79). Longer programs are thought to produce greater gains and maintenance of benefits, with a minimum of 8 weeks recommended to achieve a substantial effect (1, 79–83). The optimal duration for the individual would normally be the longest duration that is possible and practical given programs longer than 12 weeks have been associated with greater long-term benefits versus shorter programs (1, 52, 75, 76, 79).

Importantly, the beneficial effects in symptoms and 6MWT distance achieved with long-term pulmonary rehabilitation training have been shown to vanish after 24 weeks of follow-up (68). Thus,

—-1
—0
—+1

Table 3.3 ACSM FITT Aerobic Recommendations for Those with COPD

FITT	Aerobic
Frequency	At least 3–5 days/week
Intensity	Moderate to vigorous intensity (i.e., 50%-80% peak work rate or 4–6 on the Borg CR10 Scale or 12–14 RPE scale)
Time	20–60 minutes/day at moderate to high intensities as tolerated; if the 20–60 minute durations are not achievable, accumulate ≥20 minutes of exercise interspersed with intermittent exercise rest periods of lower-intensity work or rest
Type	Common aerobic modes, including walking (free or treadmill), stationary cycling, and upper-body ergometry

Key: CR = category-ratio, RPE = rating of perceived exercise

Data from ACSM (2018).

Table 3.4 ACSM FITT Aerobic Recommendations for Those with Asthma

FITT	Aerobic
Frequency	3–5 days/week
Intensity	Begin with moderate intensity (i.e., 40%-59% of HRR or $\dot{V}O_2R$); if well tolerated, progress to 60%-70% of HRR or $\dot{V}O_2R$ after 1 month.
Time	Progressively increase to at least 30–40 minutes/day
Type	Aerobic activities using large muscle groups such as walking, running, cycling, swimming, or pool exercises

HRR: Heart rate reserve; $\dot{V}O_2R$: Volume of oxygen consumption reserve.

Data from ACSM (2018).

there may be an optimal duration of training for the pulmonary rehabilitation participant to "peak" in many physiologic parameters, and further research should lend insight into this optimal threshold of training.

If program constraints will not allow for supervised exercise at least 3 days per week, two supervised and one or more unsupervised sessions per week, in the home, with specific guidelines and instruction, may be an alternative option (1, 2, 16). If the patient is very debilitated, the duration of the initial exercise sessions can be shorter with more frequent rest breaks; however, the ultimate goal is to achieve fewer or no rest breaks and at least 30 minutes of endurance exercise within the first few weeks of rehabilitation.

Exercise training of the arms is very beneficial in patients with chronic lung disease, although most of the evidence comes from patients with COPD (78, 86, 87). Patients with moderate to severe COPD, especially those with mechanical disadvantage of the diaphragm due to hyperinflation, have difficulty performing ADLs that involve use of the upper extremities (87). Arm elevation is associated with high metabolic and ventilatory demand, and activities involving the arms can lead to irregular or dyssynchronous breathing (86). This happens because some arm muscles are also accessory muscles of inspiration. Benefits of upper-extremity training in COPD include improved arm muscle endurance and strength, reduced metabolic demand associated with arm exercise, and increased sense of well-being. In general, benefits of upper-extremity training are task specific. Because of its benefits, upper-extremity training is recommended in conjunction with lower-extremity training as a routine component of pulmonary rehabilitation (1, 2, 52, 83–89).

Arm ergometry exercise is well tolerated by most pulmonary patients and is particularly beneficial for those who can only walk short distances, who

-1—
0—
+1—

574-76386_ch03_1P.indd 36 30/11/18 10:20 PM

Table 3.5 Upper- and Lower-Body Modalities Used for Cardiovascular Conditioning in Pulmonary Rehabilitation

Modality	Upper Body (UB), Lower Body (LB) or Combined (C)
Indoor track or ground walking (patient may walk with or without a rollator or walker)	LB
Treadmill	LB
Stationary upright cycle ergometer	LB
Upright dual action stationary cycle, one-legged training	C
Recumbent cycle	LB
Pool for water exercise/swimming	C
Stepping machine or steps with handrails	LB
Stationary arm ergometer	UB
Stationary rower	C
Modified aerobic activities (e.g., dance, Tai Chi, calisthenics)	C
Elliptical trainer (with or without arm cranking)	LB or C
Recumbent dual action stepping ergometer (e.g., NuStep™)	C
Wall or machine pulleys	UB
Seated aerobic activities (e.g., arm lifting, leg lifts) with or without hand or ankle weights	C

are obese, who have neuromuscular or orthopedic diseases, or who are wheelchair bound.

Caution should be taken with certain exercises in select patients, including those with osteoporosis (known or suspected due to oral steroid therapy) who may have decreased bone density and have an increased risk of vertebral compression fractures. These precautions include avoiding excess spinal flexion and rotation (90). Postoperative thoracic surgery patients (e.g., lung transplant) are generally restricted from upper-body exercise for 6 to 8 weeks postoperative to allow for internal and external incisional healing. Clearance for upper-body exercises is usually based on approval from the thoracic surgeon or transplant team (23).

Intensity of Exercise

The most challenging aspect of developing the exercise prescription for the pulmonary patient is estimation of the proper exercise intensity (16, 57, 81). The rehabilitation team must be prudent in ensuring that the exercise intensity is not too intense to provoke adverse physiologic reactions, yet is sufficient enough to promote a training effect. Individualized initial and ongoing assessments of subjective and objective findings are used to carefully advance intensity of exercise, often following incremental advancement of time. Supervised exercise training coupled with use of dyspnea control techniques works to enhance coping with fear and discomfort associated with breathlessness that often limits exercise capacity; therefore, most types of exercise that the patient enjoys or is willing to do can be beneficial. When developing the exercise prescription, the rehabilitation team must incorporate the patient's individual activity goals into the training plan. For example, if the patient wants to be able to walk the dog for 30 minutes each day at a relatively slow but steady pace without rest stops, the intensity of training should, in part, be designed to help accomplish that goal.

—-1
—0
—+1

As previously noted, both low- and high-intensity exercise training may be used to improve patient exercise tolerance. Principles of basic exercise training suggest that the intensity of exercise should be related to degree of disability, disease state, exercise test results (e.g., 6MWT, CPET, GXT, ISWT), time, workload, physiologic responses observed during exercise, and other factors. Please refer to tables 3.3, 3.4, and 3.5 for exercise intensity recommendations for patients with COPD and asthma, respectively.

High-Intensity Exercise Training

Aerobic endurance training for those with chronic lung disease may be performed at low, moderate and even high intensities (3, 55–59). High-intensity training of 60 to 80% of peak work rate may be undertaken to gain maximal physiological improvements in aerobic fitness. These improvements include increased $\dot{V}O_2$max, delayed anaerobic threshold, decreased HR for any given work rate, increased oxidative enzyme capacity, biochemical cellular changes, and capillarization of muscle (3, 55–58). These physiologic changes can result in a lower ventilatory requirement for a given exercise task as well as a more efficient pattern of breathing, with reduced dead space ventilation due to increased tidal volume and decreased respiratory rate. High-intensity training has been associated with substantial gains in exercise endurance (3).

Not all patients can tolerate sustained high-intensity exercise at the outset of training. Those patients working at their maximal tolerated exercise level will achieve gains over time (55, 57). Interval training, alternating periods of high and low intensity (or rest), has been shown to be an effective training option for persons who cannot sustain extended continuous periods of higher-intensity exercise (55, 56, 59).

Traditional physiologic changes associated with aerobic fitness from high-intensity training are not required to improve exercise tolerance and function in many patients with chronic lung disease. This is important because unpleasant dyspnea and leg fatigue associated with high-intensity exercise may interfere with its incorporation into the patient's daily lives, which affects overall exercise adherence. Moreover, it has not been proven conclusively that high-intensity exercise, with achievement of physiological gains in aerobic fitness, leads to greater improvement in day-to-day functional activity. Thus, lower-intensity aerobic exercise training can lead to significant improvements in exercise endurance, even in the absence of measured gains in aerobic fitness (60–62).

Exercise prescription using METs and MET minutes (see table 3.6) is commonly employed in pulmonary rehabilitation, using a predetermined MET range level for exercise intensity determined from a test of functional capacity. If the results from a CPET are available, one can prescribe exercise using the $\dot{V}O_2$ reserve technique from peak $\dot{V}O_2$ values (16). Peak functional capacity can also be estimated from common metabolic equations employed using GXT and 6MWT results. The rehabilitation team may also choose to have the patient perform any of the following to help gauge exercise intensity:

- Work up to a selected level on a perceived exertion scale or dyspnea level (e.g., 4 to 6 on the Borg CR10 Scale or 12 to 14 on a 6 to 20 RPE scale) (16, 91–93).
- Utilize a numeric rating scale (NRS) (94) or VAS (95–96) (see figure 3.12) to quantify perceived exercise intensity.

Any of these techniques can help guide the pulmonary rehabilitation practitioner in the development of the intensity component of the exercise prescription. Further information on the use of these scales may be found within the selected references.

Another guide for prescribing exercise intensity is using an exercise target HR range (e.g., heart rate reserve or Karvonen method) determined from an initial or follow-up exercise test, or from observations of the patient's HR responses during exercise sessions (16). However, target HR range is not always applicable during exercise training sessions in pulmonary rehabilitation programs due to a myriad of factors that can influence resting and exercise HR responses of the patient with chronic lung disease such as medications, resting dyspnea and deconditioning. Nevertheless, it is prudent to be aware of the patient's HR responses at rest and during exercise. Many pulmonary rehabilitation programs use intermittent "quick-check" HR monitoring during exercise from ECG, HR taken from pulse oximeter readings, and, if available, HR monitored via telemetry to a base station during exercise training. Any uncertainty regarding accuracy of HR based on oximetry reading should be correlated with checking radial or apical HR.

-1—
0—
+1—

574-76386_ch03_1P.indd 38 30/11/18 10:20 PM

Table 3.6 Methods for Determining Exercise Intensity for Pulmonary Rehabilitation Participants

Method	Description
Heart rate reserve (HRR) (16)	Target Heart Rate (THR) = $[(HR_{max} - HR_{rest}) \times \%\ intensity] + HR_{rest}$
$\dot{V}O_2$ reserve ($\dot{V}O_2R$) (16)	Target $\dot{V}O_2 = [(\dot{V}O_{2max} - \dot{V}O_{2rest}) \times \%\ intensity] + \dot{V}O_{2rest}$ Note: $\dot{V}O_2R$ may be determined from CPET results or estimated $\dot{V}O_2$ from established metabolic equations from GXT results, 6-minute walk tests, or other measurement of peak functional capacity.
Visual analog scale (VAS) (157, 158)	The VAS can be presented in a number of ways, including scales with a middle point, graduations, or numbers (numerical rating scales); meter-shaped scales (curvilinear analogue scales); "box-scales" consisting of circles equidistant from each other; and scales with descriptive terms at intervals along a line (e.g., Likert scale).
Numeric rating scale (NRS) (92, 93)	Unidimensional numeric rating scale (0–10) that measures the general severity or perceived intensity of subjective symptoms or dyspnea at a given point in time.
Borg CR10 Scale modified for dyspnea (16, 90, 91)	Level of perceived dyspnea measured on a 0–10 scale, with 0 being "no breathlessness at all" and 10 being "maximal."
% of METS (16)	1 MET (metabolic equivalent) = 3.5 mlO_2/kg/min. If the subject's actual or measured $\dot{V}O_{2peak}$ was 19.7, their peak MET level is 5.6 METS (19.7 ml O_2/kg/min. / 3.5) (103). If you use ACSM recommended aerobic exercise intensity levels for asthmatics (40 to 59% $\dot{V}O_2R$), the MET exercise intensity range = 2.2 to 3.3 METS (.40 × 19.7 to .59 × 19.7).
MET minutes (16)	A MET minute is a unit used in exercise prescription to quantify energy expenditure by factoring in the time spent exercising. Example: You want your patient to exercise at 60% of their functional capacity (6.7 METS) for 30 minutes, 4 days/week. 4 METS × 30 min. = 120 MET minutes/day. 120 × 4 days/week = 480 MET minutes/week (weekly exercise prescription at a 4 MET level).
Kilocalories (kcal) from METS (16)	Example: 65 kg patient 1 MET = 1 kcal/kg × hour; 5 METS = 5.05 kcal/kg × hour (65 kg subject) 5.05 kcal/~~kg~~ × ~~hour~~ × 65 ~~kg~~ = 5.47 kcal/min 60 min/~~hour~~ You would like your patient to burn ~150 kcal during their exercise session, so they would exercise ~27 minutes.

Key: ACSM = American College of Sports Medicine; CPET = cardiopulmonary exercise test; GXT = graded exercise test; $\dot{V}O_2$ = oxygen uptake

Data from ACSM (2018); Biskobing (2002); Borg (1982).

574-76386_ch03_1P.indd 39 30/11/18 10:20 PM

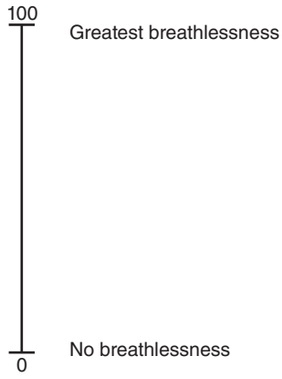


Figure 3.12 Visual Analog Scale

Oxyhemoglobin Monitoring During Exercise Training

In exercising patients with chronic lung disease, it is very important to evaluate and monitor SpO_2 to determine the need for supplemental oxygen. In particular, the arterial oxygen levels of patients with chronic lung disease change with exercise in an unpredictable fashion and cannot be reliably predicted by any measurement made at rest (97). In general, oxyhemoglobin saturation should be maintained at or above 88% during exercise. (16, 29, 98–99). Cutaneous oximetry from finger or handheld pulse oximeters provide an estimate arterial oxygen saturation (SaO_2) with general reliability of SpO_2 during walking, including 6MWT, with mean differences of 1 to 2% (35, 36). Measurements of SpO_2 are generally reliable when an accurate pulse signal is observed. Change in SpO_2 may be more variable in patients with interstitial lung disease, including idiopathic pulmonary fibrosis and systemic sclerosis, such as scleroderma (35). Use of alternative probe sites, including forehead, earlobe, or alternate fingers, may be considered if improved SpO2 accuracy is achieved. Supplemental oxygen therapy should be always readily available in the rehabilitation setting for those patients with hypoxemia during exercise.

Interestingly, some studies indicate that supplemental oxygen allows for higher levels of exercise training in COPD patients who do *not* have significant desaturation or are nonhypoxemic (2, 100–101), including those who participate in high-intensity training (72), while other studies do not have the same findings (102). The mechanisms underlying this potential benefit are unclear, but might involve decreased dyspnea from decreased carotid body stimulation, allowing for a slower respiratory rate and longer expiratory time, thereby decreasing dynamic hyperinflation. Reduced pulmonary vascular resistance may also be important. It is premature to recommend oxygen supplementation for nonhypoxemic pulmonary rehabilitation participants at this time until further research has been conducted.

Previously unrecognized exercise-induced oxygen desaturation should be documented and promptly reported to the patient's physician to facilitate a home oxygen prescription. Pulse delivery of oxygen via electronic demand device may not provide adequate SpO_2 for those patients during activity. Instead, continuous flow delivery of oxygen may be required, particularly in the patient with fibrotic lung disease. Patients should ultimately be tested during the maximal intensity level exercise they may undertake when at home, using the type of portable oxygen system that they use outside the program. The adequacy of the patient's oxygen system and flow rate recommendations during activity and exercise should be reported to the patient's physician. Patients requiring oxygen should be encouraged to obtain an oximeter and trained in ongoing monitoring of SpO_2 and oxygen in collaboration with the prescribing clinician.

In obstructive lung disease, it is also important to optimize bronchodilation and other pharmacological therapy before and during exercise training. This includes assuring not only that maintenance bronchodilators are taken, but also that short-acting bronchodilators are taken (when indicated) before initiating exercise (1, 2). Optimization of respiratory status allows for exercise training at higher intensities in patients with dyspnea limitation. Short-acting bronchodilators should also be part of any emergency kit in the exercise area.

VOLUME, PATTERN, AND PROGRESSION OF EXERCISE TRAINING

Currently the optimal volume (total amount of exercise during each session), pattern (sequence of exercise on various modalities, including rest periods), and progression of exercise training (providing an adequate training effect) remain unknown and require further investigation. A collaborative,

-1—
0—
+1—

574-76386_ch03_1P.indd 40 30/11/18 10:20 PM

multidisciplinary approach is typically used to develop the optimal volume, pattern, and progression of exercise based upon patient-specific characteristics. Gradual increases of exercise workload and intensity should be incorporated over time to provide the optimal training effect for the patient. This will vary by the severity and type of lung disease, the physical capabilities of the patient, age, gender, mobility, and many other factors. With further research, evidence-based guidelines may be developed with regard to these three very important parameters.

RESISTANCE EXERCISE TESTING

Chronic pulmonary disease not only damages the lungs but contributes to overall skeletal muscle dysfunction as well (16, 21, 52, 91). It has been well established that patients with COPD have diminished peripheral and overall muscular strength (22, 103–106). This decrease in strength is accompanied by a reduction in muscle cross-sectional area (105), muscle mass (1, 2, 52, 103) and mobility (103). Peripheral muscle atrophy and weakness combined with weak chest and thoracic muscles along with reduced muscle capillarization contribute to decreased energy expenditure, decreased resting metabolic rate, and a more sedentary lifestyle. Many pulmonary rehabilitation participants present not only with significantly reduced strength, but osteopenia and osteoporosis as well from the detrimental effects of sedentary living, chronic hypoxemia, malnutrition, and prolonged use of corticosteroid therapy. These combined effects may result in overall muscle weakness, increased risk of falls, and permanent injury or disability. Resistive exercise training can help the patient

Recent investigations have shown that resistive exercise training is beneficial in patients with COPD by increasing QOL (52), upper- and lower-body strength (1, 2, 4, 5, 8, 11, 52), and muscle size or mass (5, 52). For these and other benefits, resistive exercise training has now become an integral component of most pulmonary rehabilitation programs. Unfortunately, the effects of resistance training on disease outcomes are not well understood and few evidence-based resistive exercise recommendations currently exist in the literature for those with chronic lung disease. Most research has traditionally been performed on patients with COPD. The effects of resistive exercise training have not been well researched in patients with restrictive lung disease, pulmonary hypertension, cystic fibrosis, and other chronic lung conditions. Published evidence-based guidelines also vary somewhat with respect to resistance exercise prescription in pulmonary patients (95). Other confounding factors for developing evidence-based guidelines include a variation across studies of the number of repetitions performed, amount of weight lifted, rest interval duration between devices, total volume of work performed, pulmonary medications taken that may affect physiologic responses, upper-body versus lower-body exercise protocols, and the patient population, which oftentimes includes men only.

Therefore, the pulmonary rehabilitation practitioner who performs resistive exercise testing and training should rely on individual patient characteristics and published recommendations as well as their own knowledge of exercise prescription techniques. This is especially important for other clinical pulmonary populations until further research studies have been performed and consistent evidence-based guidelines established.

Resistance exercise testing and training serve many important purposes in today's pulmonary rehabilitation program, including:

- To let the patient know how they compare to those in their age and gender group,
- To let the patient know how much they are improving or regressing throughout pulmonary rehabilitation,
- To help determine the patient's ability to perform basic ADLs (e.g., dressing, picking up items, housework, squatting),
- To measure individual success in resistive exercise with validated normative data,
- To boost confidence and self-efficacy,
- To help assess posture, balance, and mobility issues and to prescribe posture and balance exercises,
- For documentation of preresistive and postresistive testing results for documentation of patient improvements in muscular strength and endurance for outcomes assessment, and
- To assess and determine the individual needs of the patient with respect to their unique overall muscular weaknesses.

Prior to resistance training, the patient should be evaluated for any joint or musculoskeletal abnormalities or discomfort. The standard for

—-1
—0
—+1

determining muscular strength in pulmonary populations in most research studies has traditionally been the one repetition maximum test (1-RM) (7, 16, 103, 107–109). This test involves having the patient perform an adequate warm-up and then lifting as much weight as they can for one maximal repetition with correct form and without straining. Protocols for determining the 1-RM threshold vary by the investigation. Some investigators utilize 3-RM, 5-RM, and even 10-RM preliminary testing to determine the final 1-RM threshold. While 1-RM testing has been shown to be safe in both male and female pulmonary rehabilitation participants (7, 104), machine weight exercise oftentimes may not be prescribed until later in the program (if at all), depending upon the patient. Various techniques to determine the initial resistive training workload exist. These techniques include performing a "modified" RM (e.g., 3-RM to 8-RM), where the pulmonary rehabilitation practitioner progressively increases the workload to determine the maximal amount of weight that can be lifted up to eight times with proper form and physiologic responses, and then prescribing a percent of this workload for exercise prescription. Another technique involves a gradual "titration" of weight over time. With this technique, the practitioner initially has the patient perform 10 repetitions comfortably on a piece of upper- or lower-body weight equipment and with lighter weights. The patient then progresses to 15 repetitions per session, increasing the weight load incrementally based on dyspnea or rating of perceived exercise by 1 to 2 pounds gradually over time. Finally, a validated rating of perceived exertion scale or a VAS may be used to rate resistive exercise intensity, starting with low resistance and low numerical ratings and progressively increasing to higher resistance and higher ratings over time. Patients should be reassessed prior to any increase in resistance training intensity or duration.

An inexpensive and effective "resistive circuit" may be developed if space is available. An example of this type of resistive circuit training could include the following stations:

- Dumbbell lifts (chair and dumbbells of varying weights required)
- Bands or tubes (chair and elastic bands or tubes of various tensions required)
- Medicine ball toss station (chair and medicine balls of various weights required)
- Hand-grip squeeze station (tennis balls, squeeze balls, or handgrip devices required)
- Leg-lift station with ankle weights or weighted shopping bags (chair and ankle weights or cloth shopping bags with full cans or stones required)
- Stair step station (adjustable step or set of steps required)
- Station where the patient can perform multiple resistive exercises using their body weight such as standing leg lifts, arm circles, chair raises, squats, or repetitive sit to stand (stable chair required)

Thus, with some creativity, an excellent, relatively inexpensive resistive training circuit can be developed for both the upper and lower body to incorporate the resistive component into pulmonary rehabilitation sessions.

Types of Resistance Modalities

Resistive exercise training can be performed using a number of inexpensive modalities in pulmonary rehabilitation. Patients in the pulmonary rehabilitation setting may be introduced to resistive exercise early in the program with elastic bands or tubes of varying strengths, hand weights, ankle weights, dumbbells, or may use their own body weight with or without chairs (e.g., leg lifts, seated leg extensions, squats, sit to stand, chair presses with both arms). Modalities such as these may be incorporated into warm-up/cool-down activities, used during a specific time period during the pulmonary rehabilitation session in a circuit station format (as described previously), or performed one-on-one with the patient and a pulmonary rehabilitation practitioner. Weight machines and pulley devices using heavier resistance may be used for the participant once they have acclimated to aerobic exercise training and have been cleared by their referring clinician for heavier workloads (108). There are currently no evidence-based recommendations on the time frame for the pulmonary rehabilitation participant to begin heavier resistive training after program entry. Thus, each patient must be evaluated individually with respect to resistive workload, taking into consideration their type and severity of lung disease, existing comorbidities (e.g., cardiovascular status), musculoskeletal limitations, and degree of frailty.

Rate of Progression

The rate of progression is a very important component of the resistive exercise prescription and

-1—
0—
+1—

574-76386_ch03_1P.indd 42 30/11/18 10:20 PM

ACSM FITT Resistive Exercise Recommendations for Patients with COPD or Asthma

The ACSM FITT (Frequency, Intensity, Time, and Type) principles are evidence-based resistive exercise recommendations for patients with COPD and asthma (table 3.7) (16). These guidelines may apply only to patients with either COPD or asthma, as further research needs to be performed on patients with other types of chronic lung disease before evidence-based guidelines may be presented for these populations. Some of the recommendations presented may not be applicable to specific patients depending upon their individual characteristics, comorbidities, and frailty. Certain patients may not be able to effectively perform sustained aerobic exercise during pulmonary rehabilitation sessions. Thus, low-level resistance exercise may be a good alternative for these patients. While the ACSM recommends two to four sets of exercises to improve muscular strength, other investigators have found that one set of resistive exercises provides comparable strength and physical function improvements in COPD patients compared to multiple-set protocols (7). Nevertheless, these recommendations may help to provide a framework for the pulmonary rehabilitation practitioner in the development of individualized resistive exercise prescriptions for patients with either COPD or asthma.

The ACSM FITT recommendations are also supported, in part, by the American Thoracic Society and the European Respiratory Society (1). The ATS/ERS guidelines recommend that resistance exercise guidelines should follow the same ACSM FITT principle for apparently healthy and older adults (1, 106). The AACVPR currently does not state a specific FITT recommendation for resistive exercise in pulmonary patients (29).

Table 3.7 ACSM FITT Resistive Exercise Recommendations for COPD and Asthma

FITT	Resistance Exercise
Frequency	2–3 days/week
Intensity	*Strength:* 60%-70% of 1-RM for beginners; ≥80% 1-RM for experienced weight trainers *Endurance:* < 50% of 1-RM Assessment of dyspnea or RPE using a validated scale may be considered.
Time	*Strength:* 2–4 sets, 8–12 repetitions *Endurance:* ≤2 sets for 15–20 repetitions
Type	Weight machines, free weight, or body weight exercises

Key: RM = repetition maximum, RPE = rating of perceived exertion

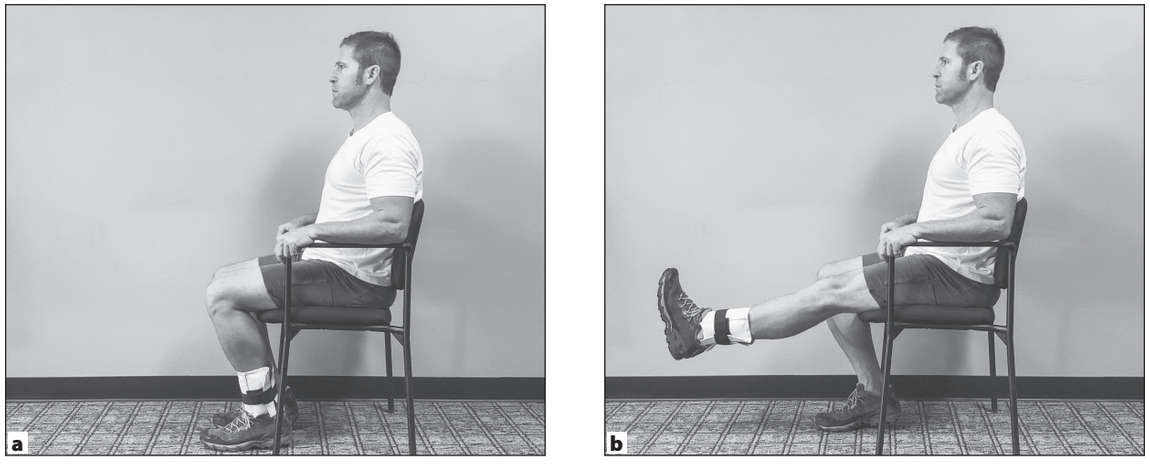
Adapted from American College of Sports Medicine (16).

should be individualized to the patient based upon risk stratification criteria stated previously. The most important part of rate of progression is utilization of the overload principle. Upper- and lower-body musculature must be stressed in a gradual, progressive manner over time for the patient to gain the most benefits from resistive training (1, 109). The principle of overload involves increasing the exercise dosage over time to maximize gains in muscular strength and endurance. This can be achieved by increasing the intensity (weight or resistance), total repetitions per set, repetition speed or rhythm, number of sets of each exercise, and/or decreasing the rest period between sets or exercises (16, 108, 109). Reassessment is required before any advancement of intensity or time and only one feature of intensity should be increased at a time.

OTHER TESTS OF MUSCULAR FITNESS

The pulmonary rehabilitation practitioner may choose from any number of validated physical function tests to assess muscular strength and endurance prior to pulmonary rehabilitation participation. The patient can then be tested periodically at regular intervals throughout program participation for outcomes documentation and assessment of improvement or decline. Moreover, upper- and lower-body muscular power (e.g., watts)

—-1
—0
—+1



Seated knee extension. *(a)* Sit in chair with back supported. Ankle weight strapped around ankle. Start with knees bent to approximately 90 degrees, feet resting on floor. *(b)* Straighten one knee and dorsiflex ankle ("toes pointing toward nose"). Pause, then return to start position. Repeat. Perform this exercise on both legs. Considerations: For taller individuals, use higher chair surface or rolled-up towel behind knee. For those with knee pain, work within a pain-free range of motion. Purpose of exercise: strengthen quadriceps/thigh muscles.

Photos courtesy of Kim Eppen.



Partial squat or knee bend. *(a)* Stand up straight while holding on to a firm surface. *(b)* Slightly bend knees while keeping hips back (body weight more on heels, not balls of feet). *(c)* Return to standing position. Repeat. Purpose of exercise: leg strengthening. This is a good option to start with for people who can't perform full sit-to-stand exercise.

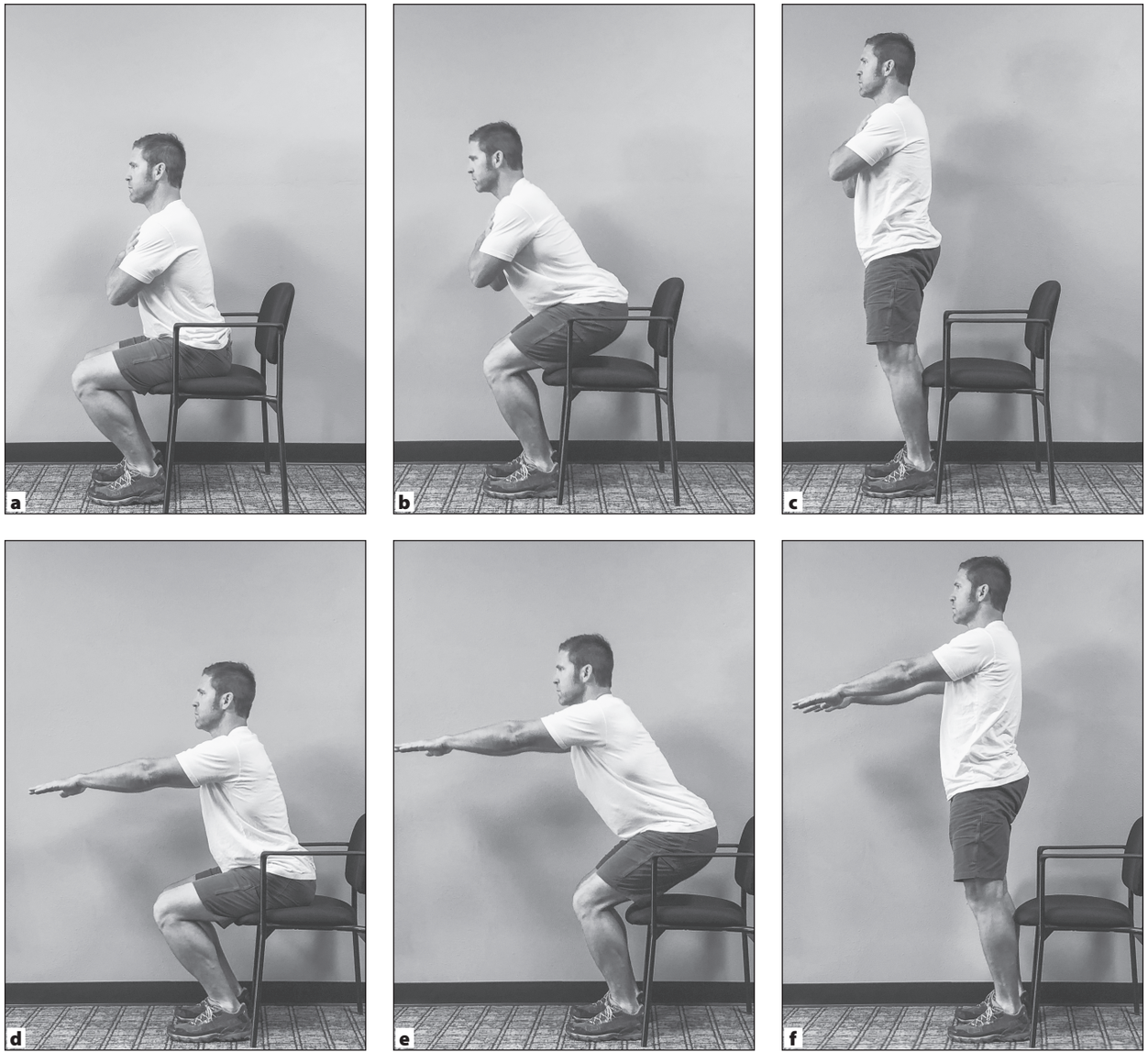
Photos courtesy of Kim Eppen.

may be assessed from some of these tests. These tests include, but are not limited to, the following:

- Timed up and go (TUG) test (110–112)
- 30-second chair stand test (113)
- 6-minute pegboard and ring test (6PBRT) (114)
- Five-times-sit-to-stand test (115)
- 30-second arm curl test (111, 116)

-1—
0—
+1—

574-76386_ch03_1P.indd 44 30/11/18 10:20 PM



Sit to stand. Option 1: *(a)* Sit toward front of chair with arms folded across chest. *(b)* Flex (lean) forward at hips. *(c)* Stand up while keeping knees behind toes. Focus on using legs, not momentum. Slowly return to seated position. Option 2: *(d-f)* Perform same exercise with arms reaching forward. Choose which option works best for each patient. Consideration: For taller individuals, those with knee pain, or significant muscle weakness, use higher chair surface. Purpose of exercise: leg strengthening.

Photos courtesy of Kim Eppen.

- Handgrip dynamometer test (117–121)
- Seated medicine ball throw test (122)
- Gallon jug shelf transfer test (123)

While normative data currently does not exist for many of these tests for pulmonary populations, these normative values may provide a reasonable reference point for the pulmonary rehabilitation participant to determine their rate of decline or improvement over time, although consideration must be given to severity and type of lung disease, comorbidities, musculoskeletal abnormalities, and hypoxemia with regular subjective and objective assessment. This data also

—-1
—0
—+1

574-76386_ch03_1P.indd 45 30/11/18 10:20 PM

shows the patient how they compare to individuals in their age category.

The ACSM (16), ATS/ERS (1) and AACVPR (29) have presented varying but similar recommendations (106) on ways to incorporate resistive exercise progression within the formal pulmonary rehabilitation exercise prescription. The ACSM focuses on a gradual progression, increasing resistance, repetitions, or frequency per session over time (16). The ATS/ERS recommends increasing the weight, number of repetitions per set, and number of sets per session over time, or to reduce rest intervals when the patient can perform one or two repetitions over the desired number during two consecutive sessions (1). The AACVPR has stated that the pulmonary rehabilitation clinician should monitor the patient's RPE as well as muscle/joint fatigue, soreness, and pain over time to incorporate overload and progression. For those with osteoporosis, caution should be exercised with spine flexion or rotation and heavy weight training. For those with pulmonary hypertension, low-level resistance training with paced breathing is acceptable (29). Overall, each of these agencies offers prudent resistive exercise progression and overload guidelines and the pulmonary rehabilitation clinician may use a combination of the above approaches.

INSPIRATORY MUSCLE TRAINING

With any continuous exercise over a period of several minutes, respiratory muscles, with normal mechanical dynamics, can increase minute ventilation (tidal volume × respiratory rate). Consequently, repeating this pattern over a period of weeks at regular intervals, a training effect occurs with improved strength and endurance of the respiratory muscles. This improvement does not occur among those with mechanical disadvantages of the respiratory muscles due to disease, such as a flattened diaphragm muscle because of COPD (1). Whether more specific inspiratory muscle training, using resistive breathing devices, enhances outcome is controversial (1, 17). Some studies have demonstrated that resistance breathing leads to an increase in respiratory muscle strength and endurance, a reduction in dyspnea, walking distance, and health-related quality of life. The British Thoracic Society's guidelines on pulmonary rehabilitation in adults evidence-based clinical practice guidelines do not support the routine use of inspiratory muscle training as an adjunct to pulmonary rehabilitation (17). This therapy may be considered for respiratory patients with documented respiratory muscle weakness (e.g., due to cachexia or corticosteroid use) or persons who use an interval training technique to improve $P_I$max (maximal inspiratory pressure measured at the mouth).

Types of respiratory muscle training include flow resistive training (breathing through a progressively smaller orifice), threshold loading training (a preset inspiratory pressure, usually at some fraction of the maximal inspiratory pressure, is required), and isocapneic hyperventilation. Suggested guidelines for employing resistive inspiratory muscle training include a frequency of 4 or 5 days a week; intensities of 30% of $P_I$max and a duration of one 30-minute session per day or two 15-minute sessions over at least 2 months (29).

FLEXIBILITY TRAINING

The majority of evidence of exercise effectiveness is based on aerobic and resistance training, yet flexibility training is commonly included as part of pulmonary rehabilitation programs (1) (table 3.8). Maintaining flexibility and good posture are very important components of a pulmonary rehabilitation program. Exercises such as yoga (124) and Tai Chi can help patients maintain needed flexibility and good posture. Range of motion improvement exercises should be incorporated into each warm-up and cool-down session to help overcome the effects of postural impairments that limit thoracic mobility and therefore lung function (1, 16). Flexibility exercises may also help to improve range of motion, prevent patient falls, and improve overall QOL, although more research is needed in this area before any steadfast conclusions may be formulated.

PATIENT SAFETY

Safety, clinical stability, and prevention of muscle tears are of crucial importance, especially for persons on chronic steroid therapy who may be at risk of muscle or tendon rupture when exposed to high-intensity loads. Furthermore, strength training precautions are warranted for postsurgical pulmonary patients, those with osteoporosis, and patients diagnosed with pulmonary arterial hypertension (PAH) and moderate to severe pulmonary

-1—
0—
+1—

574-76386_ch03_1P.indd 46 30/11/18 10:20 PM

Table 3.8 ACSM Evidence-Based FITT Recommendations for Flexibility Training in Patients with COPD or Asthma

FITT	Flexibility
Frequency	> 2–3 days/week, with daily being most effective
Intensity	Stretch to the point of feeling tightness or slight discomfort
Time	10–30 seconds for static stretching; 2–4 repetitions of each exercise
Type	Static, dynamic, or proprioceptive neuromuscular facilitation (PNF) stretching

Adapted by permission from American College of Sports Medicine, *ACSM's Guidelines for Exercise Testing and Prescription,* 10th ed. (Philadelphia, PA: Lippincott Williams & Wilkins, 2018), 257.

hypertension (PH). Light resistance exercise training using dumbbells has been shown to be safe (i.e., no severe adverse effects) in patients with PH (125). However, it is very important to instruct the patient to avoid lifting heavy weights and any breath holding or Valsalva to avoid abnormal increases in intrathoracic pressure and blood pressure during any type of resistive exercise. Until resistance guidelines are established for patients with PH, the pulmonary rehabilitation practitioner should take a prudent approach to incorporating resistance training in this population. Light hand weights, dumbbells, ankle weights, and elastic bands or tubes may be beneficial for upper- and lower-body strength development in this selected patient population.

The need for cardiovascular monitoring may be less of a priority for the pulmonary rehabilitation participant who performs resistance exercise compared to traditional aerobic exercise. While patients with COPD have been shown to work closer to their peak $\dot{V}O_2$ during upper- and lower-body resistance exercise training than age-matched healthy adults (126), resistance exercise training generally elicits a *lower* cardiorespiratory demand than that of aerobic exercise (127). This form of exercise demands a lower level of $\dot{V}O_2$ and minute ventilation and therefore evokes less dyspnea (123).

The pulmonary rehabilitation practitioner should monitor patients who are prone to hypertensive/hypotensive responses with periodic blood pressure checks, even during the resistance movement itself. If an exercise blood pressure can be taken, the rate-pressure product (double-product) can be determined with a measurement of HR for optimal patient safety and refinement of the resistance exercise prescription. If the pulmonary rehabilitation participant is being monitored with continuous ECG telemetry, the practitioner should continue to monitor for arrhythmias and adverse ECG changes during periods of resistance exercise training.

Certain patients will require one-on-one guidance and supervision during resistive testing and training, depending upon their risk level and frailty. Each patient should be given proper training instructions, followed by the pulmonary rehabilitation practitioner demonstrating the exercise. Mild muscle soreness and fatigue are common 12 to 24 hours after testing and training. If the patient complains of persistent or significant soreness or joint pain (>1 week), the referring pulmonologist or physician should be notified. Holding off resistance and aerobic training of the affected area is warranted until discomfort has subsided. Patients with major orthopedic limitations, kyphoscoliosis, acute episodes of joint inflammation, uncontrolled metabolic disease, a resting $SpO_2 < 90\%$, acute systemic illness (e.g., influenza), recent significant increase in dyspnea, fatigue, or who report of experiencing a "bad breathing day" may be contraindicated from resistive testing and training and require further screening.

PRECAUTIONS IN PULMONARY HYPERTENSION

The cardiovascular and ventilatory response to exercise is limited in pulmonary hypertension (PH) due to restriction in maximum cardiac output associated with increased right ventricle afterload (128–131). Persons with PH experience

multiple physiologic abnormalities during exercise, including reduced peak $\dot{V}O_2$, oxygen pulse, and low anaerobic threshold (130, 131). Evaluation and management by skilled specialists, along with the advent and use of disease-targeted agents in appropriate patients has been associated with improved symptoms, exercise capacity, and health-related quality of life in persons with PH. Exercise training is now a class IA recommendation for PH patients (131–134).

Well-designed trials have demonstrated improvement in exercise, functional capacity, and quality of life in people with PH participating in exercise training programs compared to untrained control groups, with exercise-based rehabilitation resulting in clinically relevant improvements in exercise capacity (135, 136*).* Evidence-based guidelines recommend accurate diagnosis, evaluation, and management by a PH specialist, supportive measures including oxygen, supervised exercise training, and avoidance of strenuous physical activity. Prior to exercise, patients should be referred for expert evaluation and treatment recommendations (132).

Optimal exercise training and prescription in PH have not been established, although gradual exercise protocols at low intensity and short duration are often used initially. Interval training should generally be avoided due to the associated rapid changes in pulmonary hemodynamics and risk of syncope. Based upon pulmonary and cardiovascular symptoms, HR, BP, and SpO2 response, the intensity and duration of exercise may be gradually advanced as tolerated with exercise training intensity and duration generally kept at submaximal levels (133). Moderate intensity resistance exercise is generally introduced only when the patient effectively uses appropriate controlled breathing techniques and avoids breath holding or the Valsalva maneuver. There is no evidence for restricting arm lifting above the head (with or without weights) as long as the patient consistently uses controlled breathing and the clinical response is within defined acceptable limits for dyspnea, SpO_2, HR, and blood pressure with absence of syncope or presyncope (137). Reducing or stopping exercise is recommended in the presence of chest pain, lightheadedness, palpitations, hypotension, severe dyspnea, presyncope, or syncope. Extreme caution must be used to avoid interruption of intravenous vasodilator therapy and to prevent falls for individuals taking anticoagulants.

EXERCISE-INDUCED HYPOXEMIA

Hypoxemia during exercise is a common and clinically important finding in the pulmonary rehabilitation setting (138). The incidence of hypoxemia is unknown with very limited guidance or standards available to direct evaluation and management of hypoxemia during exercise. A subset of hypoxemic patients develop severe exercise-induced hypoxemia (SEIH) (139). SEIH is defined as the need for >6 L/min oxygen to yield an $SpO_2 \geq 88\%$ (139). Negative consequences of sustained hypoxemia include pulmonary hypertension, cor pulmonale, cardiac dysfunction, arrhythmias, erythrocytosis, cognitive abnormalities, decline in self-care, and increased mortality (139). Hypoxemia may be managed with supplemental oxygen therapy to improve oxygenation. A potential concern in persons with COPD is suppression of hypoxic ventilatory drive, resulting in hypoventilation and CO_2 retention. Most cases of CO_2 retention result from ventilation/perfusion mismatch rather than respiratory drive suppression (140–142). Clinically stable COPD patients are generally at low risk for significant or unstable hypercapnia, particularly when using low-flow oxygen, although some may experience clinically important respiratory drive suppression when using high-flow oxygen (142).

In cases of SEIH, evaluation and management should be based upon a systematic approach to determining the underlying cause(s) of SEIH, and development and use of appropriate management strategies. If the patient is clinically stable based on HR, symptoms, and BP, gradually progressive, incremental, supervised exercise in a pulmonary rehabilitation setting is reasonable as long as hypoxemia is controlled and the patient demonstrates both objective and subjective clinical stability and exercise tolerance.

Underlying cause(s) of hypoxemia during exercise may be multifactorial and may include ventilation/perfusion mismatch, diffusion defect, right-to-left shunt, or alveolar hypoventilation. Hypoxemia in persons with COPD is usually due to ventilation/perfusion (V/Q) mismatch (143). A diffusion defect is a potential contributing factor, especially at higher exercise intensities (144). Hypoxemia from diffusion defect is generally well controlled versus that due to a right-to-left shunt which may be associated with a more limited

-1—
0—
+1—

574-76386_ch03_1P.indd 48 30/11/18 10:20 PM

response to supplemental oxygen. As the shunt fraction increases, some patients may be refractory to up to 100% oxygen due to shunted blood bypassing alveoli required to transfer oxygen into the bloodstream (145–147). Hypoxemia due to depressed ventilatory drive resulting from oversedation is rare in the pulmonary rehabilitation setting and is typically accompanied by hypercapnia and low pH. Chronic respiratory failure is associated with hypercapnia, near normal pH, and elevated bicarbonate. Hypoxemia is often aggravated with exposure to high altitude or during disease exacerbation.

Evaluation of hypoxemia at a minimum begins with history and physical exam, pulse oximetry at rest and exercise, and evaluation of symptoms and vital signs. Evaluation for severe hypoxemia should include arterial blood gas determination and pulmonology evaluation, if not already in place.

Hypoxemia during Exercise

In chronic lung disease, the ability of the lungs to maintain normal arterial oxygen is often impaired, with compromise of oxygen delivery particularly during exercise. Muscular demand for oxygen increases during exercise in proportion to the amount of work performed (138). Higher cardiopulmonary demand results in complex physiologic adjustments as well as significant potential for dysfunction or failure during activity (147).

Managing Hypoxemia during Exercise

Supplemental oxygen is used to increase arterial oxygen levels, decrease carotid body stimulation (reducing pulmonary ventilation, respiratory muscle work, and dyspnea) and relieve pulmonary vasoconstriction (improving cardiac output restriction). Oxygen improves the effectiveness of short- and long-term exercise training in pulmonary rehabilitation by reducing dyspnea, hypoxic ventilatory drive, and hyperinflation, as well as delaying acidosis. Ambulatory oxygen has the potential to increase mobility, compliance, exercise tolerance, and autonomy in hypoxemic patients. The pulmonary rehabilitation clinician should address appropriate equipment selection, use, and flow rate; communicate these recommendations to the clinical team, including the referring clinician; and assess the patient during rest, activity, and exercise using the patient's portable system. Patients who are unable to obtain appropriate oxygen for rest and ambulation due to lack of access or lack of provision from their medical equipment company should address these concerns with their prescribing clinician and insurance.

Developing an Oxygen Prescription for Exercise-Induced Hypoxemia

A comprehensive assessment requires evaluation of desaturation and oxygen requirements during exercise testing. While a 6MWT or other exercise test may reveal significant hypoxemia associated with exercise, a separate assessment and titration should be conducted to determine severity of desaturation and oxygen needs during usual self-walking pace as well as "purposeful exercise" or other activities of daily life. Assessment must also occur using the patient's ambulatory oxygen source. Nighttime O_2 needs require a separate assessment based on the clinical judgment of the referring clinician. All testing revealing hypoxemia and oxygen titration should be promptly communicated to the referring clinician. Most guidelines recommend oxygen titration to an SpO_2 level of ≥88–93%. Community practice of management of SEIH describes oxygen flow rates of 7–15 L/min by several types of nasal cannula and/or delivering up to 100% oxygen by mask interfaces in one small study (139). Multiple interfaces are used in the pulmonary rehabilitation setting, including nasal cannula, Oxymizer cannula and pendant, non-rebreathing (NRB) mask, Oxymask, Venturi mask, transtracheal oxygen, and other interfaces in an attempt to meet the oxygen needs of this population during exercise.

Inpatient practitioners have extensive experience with various high-flow oxygen systems, including NRB masks and heated, humidified, high-flow oxygen. These modalities have historically had limited use or availability in the outpatient setting due to comfort concerns and lack of portability during exercise. Use, safety, and effectiveness of these systems during exercise are poorly understood.

Oxygen Monitoring, Titration and Exercise Training

In hypoxemic COPD patients, long-term oxygen therapy has been found to improve survival,

—-1
—0
—+1

exercise, sleep, and cognitive performance with a therapeutic goal of SpO_2 level of ≥88–90% during rest, sleep, and exertion (1, 2, 16). Patients with ongoing desaturation despite use of high-flow oxygen require medical evaluation and management prior to resuming exercise. Optimal strategies for exercise training for SEIH patients have not been established (139). Progressive exercise routines should be based upon physiologic findings, such as an adequate SpO_2 determined from a pulse oximeter, symptom level including dyspnea and fatigue, stable heart rate and blood pressure, and the results of a 6MWT or CPET. If available, pulmonary rehabilitation programs should consider telemetry monitoring during the patient's first exercise session and ongoing telemetry monitoring in those with significant pulmonary hypertension or cardiac abnormalities. Patients with significant arrhythmias require medical evaluation and treatment before exercise is performed. Interval training should be avoided in persons with significant PH due to rapid changes in pulmonary hemodynamics and risk of syncope. Exercise should be stopped if the patient develops desaturation refractory to supplemental oxygen, significant tachycardia, arrhythmias, severe dyspnea, hypotension, severe hypertension, dizziness, or chest pain. Patients should have ongoing evaluation and management of their chronic lung disease and comorbidities by a pulmonologist, primary care provider, and other appropriate consultants.

Low-intensity exercise is recommended in the initial stages of exercise based upon evaluation of dyspnea, SpO_2, HR, blood pressure, and subjective symptoms. Guidelines support safe incremental increase in exercise intensity based on clinical stability. Exercise prescription and a home exercise program should be established and communicated to the patient as well as indications for stopping exercise and symptoms to report to their physician. Interval training exercise routines require further investigation in SEIH to determine safety and effectiveness.

HOME EXERCISE CONSIDERATIONS

Patients participating in a formal pulmonary rehabilitation program should be provided with a home exercise prescription to support ongoing exercise. All patient recommendations should be tailored to the individual based upon their performance and achievements during the pulmonary rehabilitation program. Aerobic exercise, muscular strength conditioning, range of motion exercises, and, in select patients, inspiratory muscle training should be included in the home exercise program. It is essential to consider the patient's future exercise setting when prescribing independent exercise to promote adherence to the program. For example, if the patient does not have access to weight-training machines, specific strength training exercises that the patient can perform with inexpensive modalities such as elastic resistance bands, light dumbbells, and hand or cuff weights should be recommended. The home exercise prescription should reflect activities performed during the rehabilitation program to allow the patient to proceed with confidence in their personalized independent program.

Participation in a pulmonary maintenance exercise program in a supervised setting promotes short- and long-term exercise adherence, patient and group support, clinical monitoring of cardiopulmonary signs and symptoms, and the opportunity for ongoing training and reinforcement of self-management strategies.

Home-Based Pulmonary Rehabilitation

Although pulmonary rehabilitation is typically provided in supervised outpatient or inpatient settings, growing evidence suggests that home-based exercise training can be effective (148–150). Home exercise programs should encourage exercise as well as lifestyle modifications to promote improved health and functional status. While home-based pulmonary rehabilitation offers the potential for convenience, cost savings, and increased access, several potential barriers exist. Potential concerns and limitations of home-based pulmonary rehabilitation include safety, liability, supervision responsibilities, outcome measurement, grossly inadequate or absent coverage by insurance, limited group support, and lack of well-developed, evidence-based guidelines that are widely applicable for the home setting and an equally strong evidence base of effectiveness. Ongoing, direct clinical supervision, monitoring, and management of clinical abnormalities in the home is unlikely. Technology systems supporting home pulmonary rehabilitation are in their infancy and have not been extensively tested in this setting. Older patients, particularly those who are less affluent and more disabled may be

-1—
0—
+1—

574-76386_ch03_1P.indd 50 30/11/18 10:20 PM

disconnected from e-health both physically and psychologically (151).

Technology-Supported Home-Based Pulmonary Rehabilitation

Key principles to ensure that technology-supported home-based pulmonary rehabilitation is effective include evaluation for clinical efficacy as well as safety. Goals of care should include enhancement of function, patient independence, symptom control, and improvement in quality of life. Optimized exercise safety is a key requirement for unsupervised exercise. Whether technology-supported home-based pulmonary rehabilitation has the potential to reduce health care utilization and mortality in pulmonary populations requires further research (152–154). Key areas include mechanisms for:

- Evaluation of desaturation at rest and with exercise, and oxygen titration prior to home pulmonary rehabilitation
- Patient training and return demonstration of proper use of inhaled medications and, when appropriate, secretion clearance devices
- Insurance coverage or patient payment for home pulmonary rehabilitation
- Patient support to reinforce new behaviors

As with traditional pulmonary rehabilitation programs, a patient must undergo a complete history and physical examination, symptom assessment, and discussion of optimal control and management of chronic lung disease and comorbidities prior to initiating a home exercise program. The preevaluation includes evaluation of functional capacity typically using a 6MWT, shuttle walk test (endurance or incremental), or CPET (1, 16, 29, 35). Those patients unable to walk 50 feet either unassisted or with their usual walking aid should be referred to either physical therapy for improvement in functional capacity or to a supervised inpatient or outpatient pulmonary rehabilitation. Patients should have had an ECG within the past year. Those with an abnormal ECG, cardiovascular symptoms, or poorly controlled cardiovascular disease should be referred to a cardiologist for further testing, management, and clearance before beginning a home exercise program. Patients with significant ECG or echocardiogram abnormalities or New York Heart Association class III-IV congestive heart failure require close supervision and monitoring not available in the home setting.

Home Exercise Prescription

Guidelines are lacking for home exercise. The following sections provide a general framework for home exercise in stable patients with mild to moderate chronic lung disease.

Dyspnea Control and Symptom Management

Patients should be trained in strategies for dyspnea control, including pursed-lip breathing, three-point posture, intermittent rest periods, use of electric or battery operated fan, open window, and walking in a mall or large store while leaning on a shopping cart or using a rollator or rolling walker (avoiding peak crowds). Considerations for distraction from dyspnea include use of music, TV, scenic locations, and exercising with friends or family.

Moderate breathlessness and fatigue are common symptoms with exercise, particularly during the initial weeks of training. If symptoms increase to beyond 6–10 using a valid 10-point dyspnea or fatigue scale, the patient is advised to slow down or rest until at baseline, then resume walking or activity at a slower speed. If dyspnea does not improve or worsens despite dyspnea controls, the patient is instructed to promptly contact their clinician or seek emergency care.

Adjuncts for Exercise

Tools that may support exercise include walking aids such as rollators that may improve balance, distance, dyspnea, and fatigue (155) and Nordic walking or trekking (156). Alternatively, the patient may use a usual walking aid if preferred.

Patients should be assessed for resting and exercise hypoxemia prior to home exercise along with development of an oxygen prescription and training on oxygen use and safety. Once home oxygen and prescription have been prescribed, the clinician should determine if the patient's portable ambulatory oxygen will adequately oxygenate the patient during activity by monitoring SpO2, heart rate, and dyspnea while performing 3 to 6 minutes of walking at the patient's usual pace. The patient should own an accurate oximeter and be trained in its use and goals for oxygen saturation during rest and exercise (157). If high-flow

—-1
—0
—+1

oxygen is required, consider evaluating use of a reservoir cannula or pendant to reduce continuous flow requirements. These devices require continuous flow oxygen for effective use. Patients with severe exercise-induced hypoxemia should be referred to outpatient or inpatient pulmonary rehabilitation.

Short- and long-acting bronchodilators play a key role in improving dyspnea and hyperinflation in obstructive lung disease (158). The clinician should determine if use of a short-acting bronchodilator such as albuterol alone or combined with ipratropium metered dose inhaler or nebulizer before exercise is warranted. Patients should be trained in and demonstrate proper inhaler use with regular follow-up evaluation.

The patient should be trained in self-monitoring of abnormal symptoms and appropriate management and reporting of abnormalities. The patient should have a mechanism to call for help, either with a family member or friend present, or use of a cellular phone. A summary of when to stop exercise is found in figure 3.13.

Self-Management

Self-management training is a key element of pulmonary rehabilitation and therefore must be addressed as part of home pulmonary rehabilitation. The emphasis of self-management has moved from a formal, didactic approach to a focus on collaborative self-management, behavior change, and adaptation (159). Self-management includes goal setting, problem solving, decision making, and taking action based on a predefined action plan (160, 161). Specific models for providing home self-management training are few and have not been well evaluated. Figure 3.14 identifies topics for self-management training as part of pulmonary rehabilitation. Factors influencing activation of self-management may include anxiety, illness perception, body mass index, age, Global Initiative for Chronic Obstructive Lung Disease (GOLD) COPD stage, and comorbidities (161–165).

Figure 3.13 When to not exercise and get help.

- Breathlessness, fatigue, or weakness beyond normal levels that does not improve with rest or usual management (e.g., oxygen, rescue inhaler or nebulizer, tripod position, etc.)
- Chest pain or tightness
- Heart palpations, including very slow or fast heart rates
- Muscle pain that does not improve
- Feeling dizzy or faint
- Leg pain, weakness, or cramping
- Sweating more than usual with exercise

Reprinted by permission from C. Garvey et al., "Moving Pulmonary Rehabilitation Into the Home," *Journal of Cardiopulmonary Rehabilitation Prevention* 38, no. 1 (2018): 1.

Figure 3.14 Educational topics concerning self-management

- Normal pulmonary anatomy and physiology
- Pathophysiology of chronic respiratory disease
- Communicating with the health care provider
- Interpretation of medical testing
- Breathing strategies
- Secretion clearance techniques
- Role and rationale for medications, including oxygen therapy
- Effective use of respiratory devices
- Benefits of exercise and physical activities
- Energy conservation during activities of daily living
- Healthy food intake
- Irritant avoidance
- Early recognition and treatment of exacerbations
- Leisure activities
- Coping with chronic lung disease

Reprinted with permission of the American Thoracic Society. Copyright © 2018 American Thoracic Society. M.A. Spruit et al., 2013, "An Official American Thoracic Society/European Respiratory Statement: Key Concepts and Advances in Pulmonary Rehabilitation," *American Journal of Respiratory Critical Care Medicine* 188:13–64. The *American Journal of Respiratory and Critical Care Medicine* is an official journal of the American Thoracic Society.

-1—
0—
+1—

574-76386_ch03_1P.indd 52 30/11/18 10:20 PM

Outcome Measures

At a minimum, home exercise programs should include measurement of dyspnea and physical activity. A tracking and reporting system should include the patient's resting and exercise heart rate, oxygen saturation, activity tracking using an accurate activity monitor, and oxygen flow rates if oxygen is used. For very slow walking patients, recording walking time or distance is acceptable. Pretesting and posttesting should include measurement of functional capacity such as 6-minute walk testing or shuttle walk testing, health-related quality of life, and mood (e.g., depression and possibly anxiety symptoms). A clinician should be identified to be responsible for tracking outcomes and addressing abnormal findings in home exercise (159).

EMERGENCY PROCEDURES

Appropriate emergency procedures and supplies must be immediately accessible and used appropriately in the pulmonary rehabilitation exercise and patient training areas (1, 16). All staff should regularly demonstrate competency with these emergency procedures. Minimum emergency equipment should include an oxygen source adequate for use during patient resuscitation and delivery apparatus, resuscitation mask, first-aid supplies, bronchodilator medications, and defibrillator (either clinical defibrillator or automated external defibrillator) (figure 3.15). In addition, all staff should have at a minimum current certification in basic life support for health care providers. Personnel who work with pulmonary patients should be familiar with panic and dyspnea control techniques.

In the patient with acute dyspnea, the following interventions are recommended:

- Monitor SpO_2.
- Assess cardiovascular status with HR, blood pressure, and, when available, ECG rhythm strip.
- Have the patient stop the activity and assume a comfortable breathing position.
- Encourage the patient to use pursed-lip breathing and relaxation techniques.
- Administer supplemental oxygen, if indicated.
- Use a rapid-onset bronchodilator medication, if indicated.

Figure 3.15 Emergency equipment for pulmonary rehabilitation.

- Telephone in the room
- Sphygmomanometer
- Stethoscope
- Pulse oximeter
- Clinical defibrillator or automated external defibrillator (AED)
- Oxygen with delivery apparatus
- Resuscitation mask (Ambu bag)
- First-aid supplies

If available:

- Fully equipped crash cart with emergency drugs, including bronchodilator medications*
- IV pole for fluid administration*

*A ongoing system is required for proper training and use of equipment, medications, and supplies.

Immediately summon the supervising physician, rapid response team, or code blue team if the patient continues to deteriorate despite the above emergency measures or when indicated.

DOCUMENTATION OF THE EVALUATION AND TREATMENT SESSION

As part of initial and ongoing patient pulmonary rehabilitation evaluation and reevaluation, every skilled clinician treating patients in pulmonary rehabilitation should perform an independent evaluation of each patient specific to the clinician's particular scope of practice. For example, the respiratory therapist would evaluate a patient's use of MDIs and (when appropriate) secretion clearance devices, whereas a physical therapist or clinical exercise physiologist should evaluate a patient's functional mobility. Cross-training of clinicians is appropriate and reasonable to further strengthen the competency

—-1
—0
—+1

of the clinical team and patient rehabilitation interventions. Within this evaluation, the clinician should identify the patient's problems, set goals to address these problems, and create a plan of care directed toward the defined goals. Overall, the patient initial assessment and evaluation should include the following: history of pulmonary and nonpulmonary disease; comorbidities and clinical manifestations; physician's review of pulmonary function tests, arterial blood gases (if available), and other relevant diagnostic tests; past medical history; current medications and oxygen liter flow (if used); baseline functional level; psychosocial status; ADL and mobility functional deficits; and an assessment of the patient's rehabilitation potential.

Documentation from treatment sessions should include the time and date; frequency, intensity, time, and type of exercise; education provided to the patient; patient's response to treatment; patient progress; and, importantly, rationale for continuing skilled intervention. Documentation of patient problems or deficits and the above information is summarized on the individualized treatment plan (ITP) in collaboration with the supervising physician at start of care, every 30 days, and at discharge.

SUMMARY

The importance of an exercise training program cannot be overemphasized. However, before a safe exercise program can be provided, a thorough patient assessment is required to evaluate exercise tolerance, formulate an appropriate exercise training prescription, detect exercise-induced hypoxemia or bronchospasm, and detect occult cardiac or other pulmonary and nonpulmonary limitations to exercise. The benefits of exercise training are well documented and include improved aerobic capacity, decreased dyspnea, increased physical capability, increased muscular strength and endurance, and improved quality of life. Areas requiring further research regarding effectiveness and use in the pulmonary rehabilitation setting include add-on or adjuncts to exercise (166), home- or community-based pulmonary rehabilitation (159), and use of high-flow oxygen systems (139).

-1—
0—
+1—

VISIT THE WEB RESOURCE
for links to additional resources and various tools, checklists, and forms.



APPENDIX

D

Example of a Typical Pulmonary Rehabilitation Facility and Examples of Pulmonary Rehabilitation Programs That Meet 2, 3, and 5 Days a Week

This appendix provides one example of a pulmonary rehabilitation facility, including descriptions of the various areas possible and detailed examples of activities that could be included in pulmonary rehabilitation programs.

EXAMPLE PULMONARY REHABILITATION FACILITY

Facility Areas

- Waiting or reception area
- Pulmonary rehabilitation administrative assistant's office
- Pulmonary rehabilitation program coordinator's office
- Storage room
- Classroom

Description of Areas

- Pulmonary rehabilitation waiting or reception area and office
  - Equipment includes desks, computer, chairs for patients, staff equipment and supplies, and public telephone.
- Pulmonary rehabilitation classroom
  - Equipment includes patient notebooks and supplies appropriate for pulmonary rehabilitation training, tables, chairs, whiteboard, and VCR.
- Gymnasium
  - Equipment includes exercise equipment appropriate for pulmonary rehabilitation exercise sessions (e.g., indoor level-surface track, treadmills, stationary bikes, rowing machines, stair stepper, treadmills, floor exercise space, and weights) as well as blood pressure cuffs, stethoscopes, supplemental oxygen sources, pulse oximeters, and emergency equipment.

—-1
—0
—+1

574-76386_ch14_AppendixD_1P.indd 177 30/11/18 10:20 PM

EXAMPLES OF PULMONARY REHABILITATION PROGRAMS THAT MEET 2, 3, AND 5 DAYS A WEEK

Practitioners can use these examples to create unique programs.

Typical twice-weekly, 8-week program outpatient pulmonary rehabilitation schedule*

Week 1: Nutritional and Respiratory Assessments	
Appointment date: _____	Appointment time: _____

Week 2: Tuesday 01/22/19 1:30 P.M.	**Thursday 01/24/19 1:30 P.M.**
1:30–2:30 Orientation to program; education session on lung disease 2:30–4:00 Supervised exercise	1:30–2:30 Breathing retraining and inhaler use 2:30–4:00 Supervised exercise

Week 3: Tuesday 01/29/19 1:30 P.M.	**Thursday 01/31/19 1:30 P.M.**
1:30–2:30 Lung medications 2:30–4:00 Supervised exercise	1:30–2:30 Medications part 2 or review 2:30–4:00 Supervised exercise

Week 4: Tuesday 02/05/19 1:30 P.M.	**Thursday 02/07/19 1:30 P.M.**
1:30–2:30 Food, lungs, and their relationship 2:30–4:00 Supervised exercise	1:30–2:30 What are these tests for? 2:30–4:00 Supervised exercise

Week 5: Tuesday 02/12/19 1:30 P.M.	**Thursday 02/14/19 1:30 P.M.**
1:30–2:30 Energy conservation 2:30–4:00 Supervised exercise and stairs	1:30–2:30 Preventing infection 2:30–4:00 Supervised exercise and stairs

Week 6: Tuesday 02/19/19 1:30 P.M.	**Thursday 02/21/19 1:30 P.M.**
1:30–2:30 Improving the immune system and relaxation techniques 2:30–4:00 Supervised exercise and stairs	1:30–2:00 Relaxation and panic control 2:00–2:45 Living with lung disease 2:45–4:00 Supervised exercise

Week 7: Tuesday 02/26/19 1:30 P.M.	**Thursday 02/28/19 1:30 P.M.**
1:30–2:30 Community resources 2:30–4:00 Supervised exercise	Individually scheduled 6-minute walk tests* 1:30–2:30 Benefits of exercise 2:30–4:00 Supervised exercise

Week 8: Tuesday 03/05/19 1:30 P.M.	**Thursday 03/07/19 1:30 P.M.**
1:30–2:00 Taking pulmonary rehabilitation home 2:00–3:30 Supervised exercise	1:30–2:00 Program evaluation and graduation 2:00–3:30 Supervised exercise

*Make sure there is a 5–10 minute rest break between each activity

574-76386_ch14_AppendixD_1P.indd 178 30/11/18 10:20 PM

Three-Day Pulmonary Rehabilitation Program

- Monday, Wednesday, Friday; 2-hour format
- Check-in: 10 minutes
- Warm-up and breathing retraining: 10 minutes
- Weight training and stretching: 20 minutes
- Aerobic training (ambulation on treadmill or level surface): 20 minutes
- Biking aerobic training (bike ergometer with arms and legs, legs only, or arm ergometry—patient may do one of the bike choices or a combination that would total 20 minutes): 20 minutes
- Cool-down: 10 minutes
- Education: 30 minutes
- Make sure there is a 5–10 minute rest break between each activity

Five-Day Pulmonary Rehabilitation Program

- Monday through Friday, 4-hour format
- Check-in: 10 minutes
- Circuit weight training: 20 minutes
- Pulmonary hygiene (may include chest physical therapy, nebulizer, instruction in inhaler use, or breathing retraining): 30 minutes
- Floor exercise (breathing retraining, muscle toning, stretching): 60 minutes
- Aerobic training (ambulation on treadmill or level surface): 30 minutes
- Biking aerobic training (bike ergometer with arms and legs, legs only, or arm ergometry—patient may do one of the bike choices or a combination that would total 30 minutes): 30 minutes
- Education: 60 minutes
- Make sure there is a 5–10 minute rest break between each activity.

—-1
—0
—+1

574-76386_ch14_AppendixD_1P.indd 179 30/11/18 10:20 PM

CHAPTER

4

Collaborative Self-Management and Patient Education

Gerene Bauldoff, PhD, RN, MAACVPR
The Ohio State University College of Nursing

Jane Knipper, RN, MA, AE-C, MAACVPR
University of Iowa Hospital and Clinics

Debbie Koehl, MS, RRT-NPS, AE-C, FAARC
Indiana University Health Methodist Hospital

Expert opinion and systematic reviews support the inclusion of education as an essential component of a comprehensive pulmonary rehabilitation program (1–7). As discussed in chapter 2, evaluation of the education needs of the patient and family or caregiver is the base on which an individualized education program is designed. Traditionally, education in pulmonary rehabilitation has been presented by a health care provider, one on one or in a group lecture setting, with the content being a disease-specific but not necessarily patient-specific focus. This approach has been shown to have low overall effectiveness (2). Rather than present information in the traditional didactic format, the education process that is currently recommended is to utilize the model of collaborative self-management training. This promotes learning by doing, which increases knowledge, enhances skills mastery, and increases self-efficacy (2). Traditional didactic education is insufficient to promote health behavior change and optimize disease control. Self-management training changes a patient's behavior by teaching individualized problem-solving skills that improve self-efficacy, which is defined as the patient's confidence to perform a behavior required to reach a specific goal. Continued development of innovative self-management programs is ongoing (2–5). Collaborative self-management training benefits both the patients and the caregivers. The patients become active partners in the management of their chronic lung disease. Patients gain the ability to assess their progress and problems, set goals, and problem solve (4, 5). Strategies that integrate self-management training and enhance communication between the patients and their health care providers have been shown to improve adherence to their treatment plans (7–9), reduce health care utilization, and reduce the probability of hospitalizations and readmissions (7). An important benefit of self-management strategies is reduction in non-adherence (2).

574-76386_ch04_1P.indd 55 30/11/18 10:20 PM

DEVELOPING AN INDIVIDUALIZED SELF-MANAGEMENT PROGRAM

Self-management interventions must be individualized to each patient's needs and concerns, diagnosis, disease severity, and comorbidities. Self-management training may be presented one on one or in a group setting, but the content must be sufficient to meet the specific needs of each patient. In addition, the interventions must focus on the patient's motivation to change (2).

Important characteristics to include in self-management training are as follows:

- Encourage active rather than passive learner participation (e.g., include group discussions instead of all classes in lecture format).
- Utilize a variety of presentation styles: visual, auditory, models and demonstrations, and active participation with return demonstrations (see, hear, do).
- Evaluate patient and family comprehension and skill mastery (e.g., use of teach-back, direct questioning, and observation).
- Provide repetition and reinforcement.
- Supply written material for reinforcement and for sharing with the family and caregiver.
- Encourage interaction between participants (fellow classmates and pulmonary rehabilitation professionals).
- Take advantage of teachable moments (e.g., discuss prevention of exacerbations and when to call the doctor when a patient returns after a hospitalization for an exacerbation).

IMPLEMENTING SELF-MANAGEMENT TRAINING

The most effective form and content of self-management intervention has not been standardized and is an ongoing challenge. However, the goal is clear, to target behavior change by assisting the patient in achieving the knowledge, self-confidence, and skills to effectively self-manage their disease. The training should enhance the patient's ability to

- engage in activities that promote health and prevent adverse sequelae,
- effectively interact with health care providers,
- adhere to treatment protocols, and
- self-monitor physical and mental status to inform appropriate management decisions.

Interdisciplinary team members with special training or expertise in a particular content area should present the relevant information at training sessions. Many excellent resources are available for content development. The COPD Foundation serves as the repository for the U.S. copyrighted COPD Assessment Test (see chapter 7). To access the COPD Assessment Test, register for a free account at www.copdfoundation.org.

Depending on the patient's individual needs, any or all of the topics listed in figure 4.1, may be appropriate for inclusion in a self-management training program. Education content should also be included in the Individual Treatment Plan (ITP) (see chapter 10). The content is not listed by order of importance but rather in a sequence that builds on previous information presented.

Normal Pulmonary Anatomy and Physiology

A basic understanding of the normal anatomy and physiology of the respiratory system is the foundation on which an understanding of respiratory illness can be built. It is particularly useful to use demonstration models and other teaching aids when discussing this material because laypersons frequently have difficulty envisioning the pulmonary anatomy.

Pathophysiology of Chronic Lung Disease

Content discussed regarding the pathophysiology of the patient's disease should be tailored to mirror the diagnosis that the patient has received from the health care provider. With a basic understanding of their specific respiratory disease, patients may be more willing to adhere to their prescribed therapeutic interventions.

For example:

- Link medication actions to lung physiology and symptoms, bronchodilation, airway swelling.
- Show oxygen transport through the lungs and how it varies with the different disease states and its effect on the heart.

-1—
0—
+1—

574-76386_ch04_1P.indd 56 30/11/18 10:20 PM

Figure 4.1 Educational topics (as indicated for the individual patient)

1. Normal pulmonary anatomy and physiology
2. Pathophysiology of chronic lung disease
    a. COPD
        i. Chronic bronchitis
        ii. Emphysema
    b. Asthma
    c. Bronchiectasis
    d. Restrictive lung disease
    e. Pulmonary fibrosis
    f. Pulmonary hypertension
    g. Cystic fibrosis
    h. Other
3. Description and interpretation of medical tests
    a. Spirometry
    b. Lung volumes
    c. Sleep study
    d. Pulse oximetry
        i. Rest
        ii. Exercise
        iii. Nocturnal
    e. Arterial blood gas
    f. Other
4. Breathing strategies
    a. Pursed-lip breathing
    b. Active expiration
5. Secretion clearance
    a. Coughing techniques, cough assist
    b. Postural drainage, percussion, vibration
        i. Traditional
        ii. Vest
    c. Positive expiratory pressure
        i. With vibration
        ii. Without vibration
    d. Autogenic drainage
6. Medications
    a. Oxygen
        i. Indications
        ii. Delivery systems
    b. Bronchodilators
        i. Inhaled
        ii. Oral
    c. Steroids
        i. Inhaled
        ii. Oral
    d. Proper inhaled medication technique
        i. Metered-dose inhaler
        ii. Dry powder inhaler
        iii. Use of spacer chamber
        iv. Nebulizers
    e. Antibiotics
        i. Prophylactic macrolide
        ii. Prescribed for treatment of infection
    f. Mucolytics
    g. Antitussives
    h. Other
7. Respiratory devices
    a. Metered-dose and dry powder inhalers
    b. Nebulizers, compressors
    c. Peak flow meters
    d. Oxygen delivery systems (concentrators, liquid, compressed gas, pulse)
    e. Oxygen-conserving devices
    f. Transtracheal oxygen
    g. Inspiratory muscle trainer
    h. Positive expiratory pressure (PEP)
    i. Sleep assessment equipment (oximetry, apnea monitors)
    j. Continuous positive airway pressure (CPAP), bi-level airway pressure (BiPAP) and non-invasive ventilation (NIV)
    k. Suctioning in the home
    l. Tracheostomy care
    m. Ventilator management in the home
8. Benefits of exercise and maintaining physical activities
    a. General principles
        i. Aerobic
        ii. Strength
    b. Home exercise program/maintenance exercise program
9. Activities of daily living (ADLs)
    a. Breathing strategies during ADLs
    b. Energy conservation
    c. Work simplification

(continued)

574-76386_ch04_1P.indd 57 30/11/18 10:20 PM

Figure 4.1 *(continued)*

10. Eating right
    a. General nutrition guidelines
    b. Strategies for weight loss
    c. Strategies for weight gain
    d. Type II diabetes
11. Irritant avoidance
    a. Smoking cessation
        i. Importance and benefits
        ii. Techniques
        iii. Resources
    b. Hazards of secondhand smoke
    c. Environmental and occupational irritant avoidance
12. Early recognition and treatment of exacerbations
    a. Signs and symptoms of a respiratory infection
    b. When to call your health care provider
    c. Self-management strategies for increased symptoms
        i. Action plan
    d. Vaccination
13. Leisure activities
    a. Travel
        i. Availability of supplemental oxygen
        ii. Planning for travel
    b. Sexuality
14. Coping with chronic lung disease
    a. Depression and anxiety
    b. Application of breathing strategies to panic control
    c. Relaxation techniques
    d. Stress management
    e. Care for the caregiver (as indicated)
15. Advance directive planning
    a. Importance of patient–physician–family discussion
    b. Durable power of attorney for health care
    c. Living will
    d. Prehospital medical care directive
16. Palliative care
    a. Patient–caregiver relationship
    b. Role and timing of hospice

Description and Interpretation of Medical Tests

The description and interpretation of medical tests can be very confusing to the patient, so explanations should be kept simple. Many times patients have never seen their test results, nor have they understood how their results compare to the normal range. The patient's ability to understand the medical tests and their results can facilitate adherence with treatment plans.

Here are some examples:

- Increased adherence to the use of inhaled bronchodilators after being shown spirometry that demonstrates a significant degree of postbronchodilator reversibility
- Increased adherence to the use of nocturnal oxygen or CPAP after review of pulse oximetry results during a sleep study or nocturnal oxygen study

Breathing Strategies

Every patient in pulmonary rehabilitation should be instructed in breathing strategies. If the strategies are found to reduce symptoms, the patient will adopt the strategy. Pursed-lip breathing and active expiration (contraction of abdominal muscles during exhalation) may help patients control and relieve breathlessness as well as reduce panic by improving their ventilatory dynamics and pattern. These breathing strategies may prevent dynamic airway compression and (in COPD) improve gas exchange by decreasing dynamic hyperinflation through slowing the respiratory rate. It is important to recognize that not all patients respond positively to pursed-lip breathing, and the nonresponders may develop asynchronous breathing with use of the technique (10). Patient response to use of pursed-lip breathing should be observed closely. Instruction in abdominal breathing has fallen out of favor because of the lack of evidence to support its use. One effective teaching technique to

-1—
0—
+1—

574-76386_ch04_1P.indd 58 30/11/18 10:20 PM

demonstrate the effectiveness of pursed-lip breathing in increasing oxygen saturation is to have your patient monitor oxygen saturation while walking and performing pursed-lip breathing. Breathing strategies should not be presented as "exercises" but rather as techniques that utilize the lungs more efficiently. The strategies are effective not only for decreasing dyspnea when in a panic situation but also as a preventative measure to reduce dyspnea and forestall panic. The sense of being in control of breathing when utilizing pursed-lip and active expiration increases the patient's self-efficacy.

Figure 4.2 provides an example of program documentation for educational interventions and outcomes.

Secretion Clearance

Instruction in secretion clearance techniques is important in patients who have difficulty raising sputum. Instruction should begin with controlled coughing, the least complicated technique, and progress to more complex techniques if clinically indicated. Recommendations for patients who produce excessive amounts of sputum (e.g., bronchiectasis, cystic fibrosis) are to instruct in the technique that the patient is most apt to use, since no one technique has been found to be more beneficial than any other. Emphasis should be placed on the use of inhaled bronchodilators before secretion clearance, followed with inhaled steroids and inhaled antibiotics, if prescribed. Instruction in secretion clearance techniques should utilize return demonstrations. If supplemental oxygen is used with exercise, it should also be used during secretion clearance techniques. The goal to maintain secretion clearance, without the need for hospitalization, is important in self-management and enhancing self-efficacy. It is important that the pulmonary rehabilitation professional not only be able to teach cough techniques but also understand the many devices available for secretion clearance. Devices range from Positive Expiratory Pressure (PEP) therapy, vibratory devices, and high frequency chest wall oscillation devices (the "vest"). Patients should additionally be instructed on the importance of hydration and (if needed) expectorant use.

Medications

Pulmonary rehabilitation is an excellent venue to assess a patient's oxygen needs at rest and with activity and to determine the delivery system that best meets their needs. Although the primary care or referring physician is responsible for prescribing medications, it is the role of the pulmonary rehabilitation staff to train patients in the proper use of their respiratory medications, including oxygen. Patients should be aware of what their medicines are supposed to do and what they are not supposed to do. For example, the simple explanation that oxygen is being prescribed to treat a low blood oxygen level, and that oxygen alone may not prevent shortness of breath, can improve adherence to supplemental oxygen therapy.

Individualized medication education should include the usual prescribed dosage, frequency, side effects, indications, contraindications, and potential interactions. Although the primary emphasis in pulmonary rehabilitation is on respiratory medications, a review of all medications may be clinically beneficial and improve adherence. Patients should understand the importance of maintaining a list of all medications, including complementary, alternative, and over the counter, and of telling all their health care providers what medications they are taking. This can reduce the possibility of harmful drug interactions and duplication. Medication instruction should include return demonstrations of proper inhaler technique and cleaning of the inhalation device. The use of a spacer chamber with a metered-dose inhaler is recommended if coordination of actuation and inhalation is impaired. By having a solid understanding of the proper use of their medications, the patient's self-management is enhanced.

With so many different inhaled devices on the market, nebulizers, MDI, DPIs, MDIs with built-in spacers, it is vitally important that pulmonary rehabilitation professionals ensure that patients use these devices correctly and in the proper order of administration. Many patients do not understand that an inhaler is not just an inhaler. Knowing a SABA from a LABA and a rescue medication from a controller medication is equally as important. It is the responsibility of the pulmonary rehabilitation professional to keep up to date on current medication delivery systems.

Respiratory Devices

Patients with chronic respiratory disease frequently use various types of respiratory therapy devices. Specific treatments are based on the patient's disease and individual needs. Reinforcement and additional education and training may

—-1
—0
—+1

Figure 4.2 Sample documentation for self-management education

Patient name: _____

Pursed-Lip Breathing and Active Expiration (PLB/AE)

	Intervention	Goal	Assessment	Outcome
Session 1	Review anatomy and physiology of a normal lung. Discuss consequences of airway collapse and dynamic hyperinflation. Distribute written information for reinforcement.	Awareness of effects of airway collapse	Verbalization	Met _____ Not met _____ Date _____ Comments: _____ _____ Signature: _____
Session 2	Verbally instruct and demonstrate pursed-lip breathing and active expiration. Provide written instructions for reinforcement.	Ability to properly perform pursed-lip breathing and active expiration	Return demonstration of pursed-lip breathing and active expiration	Met _____ Not met _____ Date _____ Comments: _____ _____ Signature: _____
Session 3	Verbally instruct and demonstrate the application of pursed-lip breathing and active expiration to activities of daily living (ADLs). Provide written instructions for reinforcement.	Ability to properly perform pursed-lip breathing and active expiration during ADLs	Return demonstration of pursed-lip breathing and active expiration during ADLs	Met _____ Not met _____ Date _____ Comments: _____ _____ Signature: _____
Session 4	Verbally instruct and demonstrate the application of pursed-lip breathing and active expiration to control panic. Provide written instructions for reinforcement.	Ability to properly perform pursed-lip breathing and active expiration for panic control	Return demonstration of pursed-lip breathing and active expiration to control panic	Met _____ Not met _____ Date _____ Comments: _____ _____ Signature: _____

574-76386_ch04_1P.indd 60 30/11/18 10:20 PM

be necessary to ensure that patients are correctly using their equipment and are adherent to their physician's instructions. The discussion of proper use of devices should begin by asking the patient to bring in *all* the "gizmos and gadgets" they have received from various health care interactions. Instruction should include appropriateness of use, indications, contraindications, and proper cleaning of each device.

Benefits of Exercise and Maintaining Physical Activities

The benefits of exercise and increased physical activity for patients with chronic pulmonary disease are well established (see chapter 3). Teaching this information underscores the importance of adherence to individualized exercise programs and participation in activities of daily living. To facilitate continued adherence and promote physical activity, each patient should receive an individualized home exercise program before the completion of pulmonary rehabilitation. An exercise log or diary may be useful for patients to self-record their home exercise and physical activity. The benefits of lifelong exercise should be stressed, and patients should be encouraged to continue in a maintenance exercise program in addition to remaining physically active.

Activities of Daily Living (ADLs)

Independence in activities of daily living is a primary goal for patients with chronic respiratory disease. By applying breathing strategies to ADLs and using energy conservation and work simplification techniques, patients find they have the self-confidence and breathing capacity to participate in many activities. Return demonstrations while performing ADLs are imperative. Patients who have the confidence to perform an activity in the rehabilitation setting are more apt to attempt the activity elsewhere. This confidence is an example of increased self-efficacy and improved self-management skills.

Eating Right

General nutrition principles apply to all patients who have chronic respiratory disease (see chapter 2). The pulmonary patient can fall anywhere along the weight spectrum, from severe nutrition depletion to morbid obesity. Patients should be educated on the reasons for their nutrition abnormalities, such as the increased metabolic cost of breathing resulting in weight loss, a sedentary lifestyle or oral corticosteroids resulting in weight gain, risk for the development of Type 2 diabetes and osteoporosis. Instruction should be geared to the individual needs of the patient, as determined on initial and follow-up assessments. In some instances, it may be beneficial to refer the patient for intensive nutrition counseling.

Irritant Avoidance

The major intervention in reducing the progression of respiratory disease is avoidance of inhaled irritants. Patients must learn to avoid all environmental and occupational irritants, especially firsthand and secondhand cigarette smoke. Current smokers and ex-smokers benefit from receiving information on becoming and remaining nonsmokers. Many excellent resources for smoking cessation programs are available online.

Early Recognition and Treatment of Exacerbations

The importance of teaching early recognition and treatment of exacerbations in pulmonary rehabilitation cannot be overstated. Open communication and collaboration between patients and their health care providers is essential in the early treatment of exacerbations. Strategies that teach patients to recognize an impending exacerbation and promptly initiate treatment may reduce severity and complications as well as decrease hospitalizations. The use of an action plan (figure 4.3) is a promising strategy to improve collaborative self-management. Action plans can simply instruct the patient to contact his health care provider when symptoms increase, as in figure 4.3, or if the patient has mastered a higher level of self-management, action plans can be personalized with specific medication and dosage recommendations. The appropriateness of receiving influenza and pneumonia immunizations, along with the importance of frequent hand washing and covering the mouth when coughing, should also be covered when discussing exacerbations.

Leisure Activities

The ability to participate in leisure activities is a goal of many patients attending pulmonary

—-1
—0
—+1

Figure 4.3 COPD action plan

Name: _____ Date: _____

Health care provider: _____ Phone: _____

Pharmacy: _____ Phone: _____

Green Zone

- My sputum is clear/white/usual color and easily cleared.
- My breathing is no harder than usual.
- I can do my usual activities, including exercise.
- I am able to think clearly.
- I am eating well.
- I am sleeping well.

Take your usual medicines, including oxygen, as you are told to do by your health care provider. Avoid cigarette smoke, secondhand smoke, and other inhaled irritants.

Yellow Zone

- My sputum has changed (color, thickness, amount).
- I am more short of breath than usual.
- I cough or wheeze more.
- I weigh more and my legs/feet swell.
- I have less energy and cannot do my usual activities or exercise without resting.
- My sleeping is bad, and my symptoms wake me up
- I am not eating well, I have lost my appetite.
- I am using my rescue inhaler or nebulizer more often.

Continue your daily medications. Call your health care provider. You may be told to begin taking an antibiotic and prednisone. Have your pharmacy phone number available.

Red Zone

- I cannot cough out my sputum, it is thicker, the color has changed, or there is blood in it.
- I am really short of breath, even when I rest.
- I need to sit up to breathe.
- I cannot sleep.
- I cannot do my usual activities or exercise.
- I am unable to speak more than one or two words at a time.
- I cannot think clearly, and I feel sleepy.
- I have chest pains.

Call your health care provider as you need medical care right away. You may be asked to come in to be seen, be told to go to the emergency room, or be told to call 9-1-1.

rehabilitation. Forfeiting the ability to travel is a loss that is difficult for many patients to accept. Information on the availability and use of supplemental oxygen when traveling is readily available on the Internet. Traveling with lung disease is not easy; patients need to understand how to plan for that travel. The COPD Foundation has many great resources to assist the patient with travel preparations. The inclusion of a discussion on sexuality can be intimidating for some rehabilitation staff, but with preparation, the topic can be thoughtfully presented and well accepted. There are resources available via the COPD Foundation's website to assist health care providers and

-1—
0—
+1—

574-76386_ch04_1P.indd 62 30/11/18 10:20 PM

patients. Registration is free on the foundation website (www.copdfoundation.org). Once registered, information such as the Slim Skinny Reference Guide (SSRG) provides detailed information for the health care provider.

Coping with Chronic Lung Disease

Chronic lung disease is often accompanied by comorbidities. Psychosocial comorbidities are common and are detailed in chapter 5. Pulmonary rehabilitation is an excellent setting for group discussions on panic control, where patients can appreciate that they are not alone in their fears. Shortness of breath during exercise sessions provides the opportunity to demonstrate to patients the effectiveness of breathing strategies to slow their respiratory rate and help them remain in control of their breathing. Relaxation techniques and stress management strategies should also be offered to assist the patient in preventing panic and in coping effectively with their chronic lung disease. As with breathing strategies, if the patients find relaxation techniques or stress management effective, they will adopt their use. It is also important that pulmonary rehabilitation staff recognize the burden placed on caregivers. Family and social roles often change when someone has a chronic illness. Pulmonary rehabilitation professionals should recognize when caregivers feel overwhelmed, stressed, and helpless. Referring the caregiver for support and informing them of resources is important as well. This can include friends, counselors, family physician, or even clergy.

Care Transitions: Hospital to Home

The pulmonary rehabilitation staff are important members of the care transition team. There is increasing evidence of the benefits of pulmonary rehabilitation in the acute setting, either during or shortly after hospitalization for acute exacerbation of COPD (11). The immediate posthospitalization period is a high-risk time for a new exacerbation to occur. Persistent inactivity following a hospitalization has been shown to increase the likelihood of readmission with a subsequent exacerbation. In addition, self-reported daily physical activity in patients with severe COPD has been shown to be independently associated with hospitalizations for acute exacerbation (12). Pulmonary rehabilitation staff have a responsibility to design programs to allow enrollment in pulmonary rehabilitation as soon as possible following a hospitalization. This can assist the patient in improving their functional activity tolerance and disease self-management skills, which may then prevent readmission.

End-of-Life Planning

Palliative care is an example of collaborative self-management, in which the goal is to relieve suffering and improve quality of life. Pulmonary rehabilitation can provide a forum to institute palliative care for patients with chronic pulmonary diseases. For example, end-of-life discussions and decision making require communication among the patient, family, and caregivers that can be facilitated in the pulmonary rehabilitation setting.

Palliative care may transition into hospice care. Most patients believe when the term *palliative care* is used that the end of life is looming, and the mention of *hospice* means death is imminent. Dispelling these notions by initiating discussions on these topics in pulmonary rehabilitation is appropriate and encouraged (13). Providing the opportunity to discuss options for end-of-life care leads to an increase in adoption of advance directives (durable power of attorney for health care, living will, and prehospital medical directive), and patients will become more comfortable initiating discussions with their families and physicians regarding their care.

SUMMARY

Collaborative self-management training is an essential component of comprehensive pulmonary rehabilitation. Self-management training promotes learning by doing and taking advantage of teachable moments. The recommended content should be patient-specific, yet it is imperative to include for all patients training in early recognition and treatment of exacerbations, including the use of an action plan, proper medication use with emphasis on adherence and technique for inhaled medications, and the importance of daily exercise. Educational sessions are an opportunity to facilitate the discussion of end-of-life decision making.

VISIT THE WEB RESOURCE
for links to additional resources and various tools, checklists, and forms.



—-1
—0
—+1

Survey of Exercise Prescription in US Pulmonary Rehabilitation Programs

Chris Garvey, MSN, MPA, FNP, MAACVPR; Richard Casaburi, PhD, MD; Martijn A. Spruit, PhD; Jana De Brandt, MSc

Downloaded from http://journals.lww.com/jcrpjournal by BhDMf5ePHKav1zEoum1tQfN4a+kJLhEZgbsIHo4XMi0hCywCX1AWnYQp/IlQrHD3i3D0OdRyi7TvSFl4Cf3VC1y0abggQZXdgGj2MwlZLeI= on 01/11/2021

Purpose: Pulmonary rehabilitation (PR) is the standard of care for chronic, symptomatic lung disease. Current scientific and clinical guidelines recommend PR to improve dyspnea, functional capacity, and quality of life. Several PR guidelines provide recommendations about the mode, intensity, duration, frequency, and progression of exercise-based interventions. There are variations in the components of PR exercise prescription that may influence the response to PR, as well as variations in how the exercise prescription and its components are determined and monitored. Therefore, the purpose of this investigation was to identify current PR exercise prescription practices via survey sent to 1758 PR programs in the United States.
Methods: The American Association of Cardiovascular and Pulmonary Rehabilitation administered surveys in 2013 and 2016 to US-based PR providers.
Results: Responses were returned from 371 PR providers (vs 380 in 2013). There was an increase in responses for all options describing exercise prescription methodology in the 2016 survey, with each element (frequency, intensity, time [duration], and type [mode]; FITT) demonstrating significant increase in use. There was a significant increase in 3 methods of determining exercise goals in 2016 versus 2013: duration ($P = .017$), distance ($P = .010$), and metabolic equivalents of task ($P \leq .001$).
Conclusions: The 2016 survey responses show a greater use of guideline-based exercise prescription methodology, with an increase in use of FITT methodology for exercise prescription.

Key Words: COPD • exercise • exercise prescription • outcomes • pulmonary rehabilitation

Author Affiliations: *Department of Medicine, University of California San Francisco (Mr Garvey); Rehabilitation Clinical Trials Center, Los Angeles Biomedical Research Institute, Harbor-UCLA Medical Center, Torrance, California (Dr Casaburi); REVAL—Rehabilitation Research Center, BIOMED—Biomedical Research Institute, Faculty of Rehabilitation Sciences and Physiotherapy, Hasselt University, Diepenbeek, Belgium (Dr Spruit and Ms De Brandt); Department of Research and Education, CIRO+, Center of Expertise for Chronic Organ Failure, Horn, the Netherlands (Dr Spruit); and Department of Respiratory Medicine, Maastricht University Medical Centre, NUTRIM School of Nutrition and Translational Research in Metabolism, Maastricht, the Netherlands (Dr Spruit).*

Chris Garvey is on the speaker's bureau for Boehringer Ingelheim outside the scope of this work. Richard Casaburi is a member of the speaker's bureau or advisory board for Boehringer Ingelheim, Glaxo SmithKline, Astra Zeneca, and Theravance outside of the scope of this work. Martijn Spruit has received personal remuneration for consultancy and/or lectures from Boehringer Ingelheim, GSK, Novartis, and AstraZeneca outside the scope of this work, as well as congress travel support from TEVA. Jana De Brandt has no conflicts of interest to disclose.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.jcrpjournal.com).

Correspondence: *Chris Garvey, MSN, MPA, FNP, MAACVPR, Sleep Disorders and Pulmonary Rehabilitation, Department of Medicine, University of California San Francisco, 2330 Post St, Ste 420, San Francisco CA 94115 (chris.garvey@ucsf.edu).*

Copyright © 2020 Wolters Kluwer Health, Inc. All rights reserved.

DOI: 10.1097/HCR.0000000000000467

Supervised exercise training, coupled with education and behavior change, is one of the pillars of a comprehensive pulmonary rehabilitation (PR) program for patients with chronic obstructive pulmonary disease (COPD).[1] Indeed, exercise-based PR programs are safe and generally reduce daily symptoms, improve exercise tolerance, and improve quality of life in patients with COPD.[2]

Multiple PR guidelines provide recommendations about the mode, intensity, duration, frequency, and progression of well-known exercise-based interventions.[1,3,4] Still, the duration and combination of types of exercise modalities vary to a great extent between PR programs globally,[5-8] as well as exercise training intensity and progression between individual patients with COPD.[9-11] This may, at least in part, explain the large variation in response to PR in patients with COPD.[2,11]

Stationary cycling, treadmill walking, and resistance training with handheld weights are commonly applied in North America-based PR programs,[5] yet information regarding methodology is lacking. An earlier survey was conducted by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) in 2012-2013 to evaluate PR exercise prescription practices.[12] Findings of the 2013 survey identified PR exercise prescription practices that are consistent with national guidelines; however, wide variations in measures of intensity and method of exercise progression were reported, including what the patient can tolerate, and when the patient and staff feel the patient is ready. This study describes the results of an updated 2016 survey, compares the 2016 survey results with the 2013 survey, and discusses implications of changing trends in exercise prescription development and application in the PR setting.

METHODS

SURVEY

A 15-question survey administered in 2013 has been previously described.[12] A 22-question survey was recently developed by the authors based on the 2013 survey[12] to evaluate PR exercise prescription practices in the United States (see Table 1, Table 2, and Supplemental Digital Content 1, available at: http://links.lww.com/JCRP/A167). Both surveys were developed by the authors with input from experts in PR research, exercise physiology, and program management. Survey questions asked about PR exercise prescription, methodology, exercise testing, and exercise goals. Patient education topics, oxygen titration and system used, staff clinical discipline, team makeup, patient diagnoses, program setting, and program size were also surveyed and responses are described in Supplemental Digital Content 1 (available at: http://links.lww.com/JCRP/A167). The 2016 survey was sent to all individuals listed as PR program directors in the AACVPR database. The database has a total of 1831 individual e-mail addresses. The AACVPR has identified the approximate

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

number of PR and cardiac rehabilitation (CR) programs in the United States in a recent national search, titled "AACVPR Finding the N," based on self-report (Kate Maude, BA, e-mail communication, April 26, 2017). The search determined that there are 237 PR centers and 1521 combined CR and PR centers in United States. The exercise prescription survey was sent via an e-mail message with invitation to complete the survey via surveymonkey.com. Data collection was voluntary. Analysis and statistical comparison of the survey results were performed using SPSS Statistics Version 24 (IBM Corp.). Chi-square analysis was performed to compare relationships between 2 variables: the survey outcome measures (eg, Do you develop an exercise prescription for your PR patients?: Yes or No) and the year of survey (2013 or 2016). Assumptions to perform a χ^2 analysis were met, as variables were categorical and consisted of $\geq$2 categorical, independent groups. Chi-square analysis was not performed for the following survey items: If intensity is measured, check which measure is used; and If yes, describe method of exercise used during titration (Table 1) as survey response options were different across the 2013 and 2016 survey (see Supplemental Digital Content 1, available at: http://links.lww.com/JCRP/A167). $P < .05$ was set as significant.

EXERCISE PRESCRIPTION IN PR

Exercise prescriptions may be derived from various sources including guidelines and statements from the American College of Sports Medicine (ACSM),[13] AACVPR,[14] and American Thoracic Society(ATS)/European Respiratory Society (ERS)[1] and combinations of PR guidelines and/or exercise methodologies developed by the PR program or health system.

RESULTS

Responses were returned for 371 (20.3% of requests sent) versus 380 in 2013. Survey responses regarding exercise prescription are summarized in Table 1, with a question added in 2016 in Table 2. Exercise prescription was offered to patients by >96% of respondents in both 2013 and 2016 surveys ($P = .787$; $\chi^2 = 0.073$). There was an increase in responses for all options describing exercise prescription methodology in the 2016 survey, with elements of the ACSM (frequency, intensity, time [duration], and type [mode]; FITT) demonstrating significant increase in use. Other components of exercise increased, but changes were not statistically significant: progression ($P = .304$), continuous exercise ($P = .075$), interval exercise ($P = .188$), resting intervals ($P = .151$), training intensity baseline and progression over time ($P = .426$), and supervision ($P = .405$). There was a significant increase in 3 methods of determining exercise goals in 2016 versus 2013: duration ($P = .017$), distance ($P = .010$), and metabolic equivalents of task (METs) ($P \leq .001$). Specific methodology for assessing METs was not requested or stated. There was a similar number of respondents offering a formal exercise class in 2016 versus 2013 ($P = .318$).

INTENSITY

The most frequently used measures of exercise intensity (>50% of respondents) were rating of perceived exertion (RPE), Borg 10-point dyspnea scale, 6-min walk test (6MWT), target heart rate (THR), and METs. A comparison between the 2013 and 2016 surveys was not possible, as in 2013, only one option could be selected while the 2016 survey allowed multiple options.

PROGRESSION

A new question in the 2016 survey asked about methodology used to determine progression of exercise using 1 of 11 response options versus an open-ended question used in 2013. Nearly half of the 2016 respondents reported use of RPE, Borg 10-point dyspnea scale, METs, THR, or 6MWT. The 2013 survey showed wide variability of progression methodologies, with 99 different descriptions of measures of progression. The 2016 survey lacked an open response option.

RESISTANCE TRAINING

The number of respondents using a resistance training protocol increased more than 2-fold from 40.2% in 2013 to 93.5% in 2016 ($P \leq .001$, $\chi^2 = 209.9$). Components of resistance training (not asked in 2013) included weight lifting (75.9%), elastic bands (69.0%), weight or resistance machines (57.1%), and resistance using one's own body weight, for example, wall push-ups (41.6%).

DISCUSSION

The content of the exercise training as part of US-based PR programs is changing over time. Indeed, the 2016 survey clearly shows that a majority of the PR programs develop an exercise prescription for their patients, using the FITT principles. Exercise intensity is measured more frequently using multiple methods, such as symptom ratings and heart rate. Interestingly, the number of PR programs that used any resistance training protocol doubled between 2013 and 2016. This suggests that more focus is placed on the training of lower-limb muscles to counteract atrophy-induced muscle weakness. Although weight lifting/resistance machines are used frequently for the resistance training (up to 75% of the PR programs), the 1-repetition maximum is only used in 5% of the PR programs. This suggests that there are still gains to be made to determine the progression of the resistance training.

Translating scientific evidence for PR into effective clinical care may challenge PR clinicians. A multidisciplinary model that supports competency in provision of supervised exercise training in a range of severities and manifestations of chronic lung disease as well as comorbidities is essential. The 2016 survey responses show a greater use of guideline-based exercise prescription methodology. The majority of programs provide both PR and CR. This may offer some advantages including shared use of gym, equipment, and possibly cross training for both PR and CR staff, which could improve both preparation and skills for caring of patients with multiple common comorbidities in the 2 settings. Both interventions have clear, distinct, and important differences that must be considered and applied to daily practice.

Limitations of the survey include low return rate and sample size and unknown characteristics of noncompleters. The exact number of PR programs in the United States is unknown, although recently estimated at 237 PR centers and 1521 combined CR and PR centers in United States (data provided by the AACVPR).

The AACVPR offers program certification that evaluates PR program quality, safety, staff competency, and exercise prescription. Nearly two-thirds of respondents reported that their PR program has been certified by the AACVPR. The AACVPR PR program certification requires that exercise prescription is based on AACVPR and/or ACSM guidelines. This requirement for national certification may influence exercise prescription practices. It is unclear why ATS/ERS PR guidelines are not included as an option and the exact influence of guidelines on exercise prescription methodology.

The American College of Chest Physicians (ACCP)/AACVPR PR evidence-based guidelines updated the graded

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

Table 1

Pulmonary Rehabilitation Exercise Prescription Survey Results

Question	2013 Survey Results, % (n)	2016 Survey Results, % (n)	χ^2	*P* Value
Do you develop an exercise prescription for your PR patients? (2013: n = 380) (2016: n = 371)			0.073	.787
Yes	97.1 (369)	96.8 (359)		
No	2.9 (11)	3.2 (12)		
If so, which components are included? Check all that apply. (2013: n = 338) (2016: n = 325)				
Mode	95.3 (322)	99.7 (324)	12.992	<.001
Frequency	95.6 (323)	99.7 (324)	12.001	.001
Duration	95.0 (321)	100.0 (325)	16.776	<.001
Training intensity	84.9 (287)	91.4 (297)	6.615	.010
Progression	82.0 (277)	84.9 (276)	1.056	.304
Continuous exercise	41.1 (139)	48.0 (156)	3.172	.075
Interval exercise	42.6 (144)	47.7 (155)	1.733	.188
Resting intervals	34.9 (118)	40.3 (131)	2.057	.151
Training intensity at baseline and progression over time	46.4 (157)	49.5 (161)	0.633	.426
Supervision	50.0 (169)	53.2 (173)	0.692	.405
How do you determine exercise goals for patients? (2013: n = 291) (2016: n = 315)				
Duration	87.3 (254)	93.0 (293)	5.653	.017
Distance	35.4 (103)	45.7 (144)	6.671	.010
METs (intensity)	46.0 (134)	70.8 (223)	38.265	<.001
Is a formal exercise class that addresses physical activity and concepts of exercise prescription offered to patients? (2013: n = 311) (2016: n = 319)			0.997	.318
Yes	70.4 (219)	74.0 (236)		
No	29.6 (92)	26.0 (83)		
If intensity is measured, check which measure is used: (2013: n = 322) (2016: n = 326)				
Borg dyspnea 10-point scale	30.4 (98)	80.4 (262)		
Rating of perceived exertion	28.9 (93)	86.5 (282)		
Target heart rate	7.8 (25)	73.9 (241)		
METs	10.6 (34)	53.7 (175)		
Percentage of maximum target heart rate (maximum predicted heart rate, eg, 220 − Age)	2.8 (9)	31.0 (101)		
Percentage of maximum work rate	0.3 (1)	4.3 (14)		
Percentage of heart rate reserve	0.0 (0)	11.7 (38)		
Watts	1.6 (5)	N/A		
Incremental CPET	1.6 (5)	N/A		
6MWT	15.8 (51)	79.1 (258)		
Constant work rate CPET	0.3 (1)	1.2 (4)		
1-repetition maximum	N/A	4.6 (15)		
Do you use any protocol for resistance training? (2013 n = 333) (2016: n = 325) (*Wording for 2016: Do you prescribe resistance training?)*			209.934	<.001
Yes	40.2 (134)	93.5 (304)		
No	59.8 (199)	6.5 (21)		
Describe indicators or methodology used to determine progression of exercise. (2013: n = 260; open ended responses) (2016: n = 318)				
Borg 10-point dyspnea scale	N/A	79.2 (252)		
Rating of perceived exertion	N/A	89.0 (283)		
METs	N/A	64.5 (205)		
Target heart rate	N/A	50.9 (162)		
Percent of maximum target heart rate (maximum predicted heart rate, eg, 220 − Age)	N/A	23.9 (76)		
Percent of heart rate reserve	N/A	10.7 (34)		
Percent of maximum work rate in an incremental CPET	N/A	2.8 (9)		
Constant work rate CPET	N/A	0.9 (3)		
6MWT	N/A	47.2 (150)		
One repetition maximum	N/A	5.3 (17)		
Incremental CPET	N/A	2.8 (9)		
Do you use exercise testing to establish exercise prescription? (2013: n = 314) *(not asked in 2016)*				
Yes	61.1 (192)	N/A		
No	38.9 (122)	N/A		
If yes, please indicate exercise testing used to establish exercise prescription: (2013: n = 185) *(not asked in 2016)*				
6MWT	91.4 (169)	N/A		
Endurance Shuttle walk test	0.5 (1)	N/A		
Incremental Shuttle walk test	0.5 (1)	N/A		
Constant work rate CPET	0.5 (1)	N/A		
Incremental CPET	7.0 (13)	N/A		

Abbreviations: CPET, cardiopulmonary exercise test; METs, metabolic equivalents of task; N/A, not available; PR, pulmonary rehabilitation; 6MWT, 6-min walk test.

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

Table 2

New Question for 2016

Question	Results, % (n)
If you do prescribe resistance training, which components are included? Check all that apply. (n = 303)	
Weight lifting	75.9 (230)
Weight or resistance machines	57.1 (173)
Elastic bands	69.0 (209)
Resistance using one's own weight, eg, wall push-ups	41.6 (126)

evidence base of PR in 2007.[4] The evidence base has been further strengthened by updated statements and guidelines from the ATS/ERS,[1] ACSM,[13] AACVPR,[14] as well as multiple studies. Since publication of the 2013 survey,[12] the ATS/ERS has published an updated comprehensive PR statement that updates the evidence for exercise in diverse pulmonary populations that provides detailed guidance on exercise prescription.[1] The ACSM regularly publishes updated guidelines for exercise testing and prescription.[13] Survey responses and approaches to exercise prescription suggest some variation in approaches to exercise prescription, with a trend toward more consistent use of ACSM and ATS/ERS guidelines. The updated 5th edition of AACVPR guidelines was released in 2019.[14] Variations in responses and practices may be influenced by diverse national and international recommendations, exercise prescription requirements of the AACVPR national certification, lack of formal exercise science training for many respiratory therapy and registered nurses, programs with CR focus providing PR, and various models of PR used throughout the United States and possibly regional variations. It is unclear whether diverse practices also reflect the heterogeneity of PR patients.

All major guidelines recommend a comprehensive assessment, history and focused physical examination, and baseline exercise testing before beginning PR. Initial and ongoing assessment is key regardless of the PR setting or staff composition. Long-term adherence to exercise is a major priority in PR, particularly translating gains from PR into increased physical activity.

A comprehensive PR program results in improvement in exercise capacity, dyspnea, and quality of life. Exercise training is the core component of effective PR. Exercise recommendations are available from several US and international organizations. While there are consistencies among the various guideline recommendations of aerobic and resistance training, differences exist regarding methodology and details of exercise prescription. Exercise prescription differences may reflect variations in daily practice, background, and training of clinicians and influence from professional and scientific guidelines and organizations. It may be tempting to embrace one guideline over another. However, even multisociety international statements such as the ACCP/ATS/ERS "Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease: A Clinical Practice Guideline Update" identifies a strong level of evidence for PR-only in COPD patients with a forced expiratory volume in the first second (FEV_1) of <50% predicted.[15] This is inconsistent with major PR and COPD guidelines as well as current Medicare coverage of outpatient PR that identify PR for COPD with an FEV_1 of <80% predicted. Clinicians should be familiar with major, evidence-based PR guidelines and use a collaborative, multidisciplinary team approach to individualized exercise training and prescription in the context of a PR program. A baseline and ongoing assessment that includes disease and symptom severity, comorbidities, and patient goals should be emphasized. This should be coupled with individual and aggregate measurement and analysis of patient-centered outcomes including exercise performance. PR should emphasize sustainable exercise that translates into both improved muscle function and increased physical activity.

ACKNOWLEDGMENTS

Jana De Brandt was supported by funding from the Flemish government. The research of FWO aspirant Jana De Brandt is sponsored by FWO-grant #11B4718N. The authors acknowledge and thank Kate Maude of the AACVPR and Smith Bucklin Association for her considerable assistance with survey formatting, administration, data collection, aggregation, and reporting.

REFERENCES

1. Spruit M, Singh S, Garvey C, et al. An official American Thoracic Society/European Respiratory Society statement: key concepts and advances in pulmonary rehabilitation. *Am J Respir Crit Care Med*. 2013;188(8):e13-e64.
2. McCarthy B, Casey D, Devane D, Murphy K, Murphy E, Lacasse Y. Pulmonary rehabilitation for chronic obstructive pulmonary disease. *Cochrane Database Syst Rev*. 2015;(2):CD003793. doi:10.1002/14651858.CD003793.pub3.
3. Garvey C, Paternostro Bayles MP, Hamm LF, et al. Pulmonary rehabilitation exercise prescription in chronic obstructive pulmonary disease: review of selected guidelines. *J Cardiopulm Rehabil Prev*. 2016;36:75-83.
4. Ries AL, Bauldoff GS, Carlin BW, et al. American College of Chest Physicians, American Association of Cardiovascular and Pulmonary Rehabilitation. Pulmonary rehabilitation: joint ACCP/AACVPR evidence-based guidelines. *Chest*. 2007;131:4S-42S.
5. Spruit MA, Pitta F, Garvey C, et al. Differences in content and organizational aspects of pulmonary rehabilitation programs. *Eur Respir J*. 2013;43;1326-1337.
6. Brooks D, Sottana R, Bell B, et al. Characterization of pulmonary rehabilitation programs in Canada in 2005. *Can Respir J*. 2007;14:87-92.
7. Wadell K, Janaudis Ferreira T, Arne M, et al. Hospital-based pulmonary rehabilitation in patients with COPD in Sweden—a national survey. *Respir Med*. 2013;107(8):1195-1200.
8. Camp PG, Hernandez P, Bourbeau J, et al. Pulmonary rehabilitation in Canada: a report from the Canadian Thoracic Society COPD Clinical Assembly. *Can Respir J*. 2015;22:147-152.
9. Spruit MA, Gosselink R, Troosters T, et al. Low-grade systemic inflammation and the response to exercise training in patients with advanced COPD. *Chest*. 2005;128:3183-3190.
10. Sillen MJ, Franssen FM, Delbressine JM, et al. Efficacy of lower-limb muscle training modalities in severely dyspnoeic individuals with COPD and quadriceps muscle weakness: results from the DICES trial. *Thorax*. 2014;69:525-531.
11. Spruit MA, Franssen FM, Rutten E, et al. A new perspective on COPD exacerbations: monitoring impact by measuring physical, psychological and social resilience. *Eur Respir J*. 2016;47(4):1024-1027.
12. Garvey C, Fullwood M, Rigler J. Pulmonary rehabilitation exercise prescription in chronic obstructive lung disease: US survey and review of guidelines and clinical practices. *J Cardiopulm Rehabil Prev*. 2013;33:314-322.
13. American College of Sports Medicine. *ACSM's Guidelines for Exercise Testing and Prescription*. 10th ed. Philadelphia, PA: Lippincott Williams & Wilkins. 2017:334-338.
14. American Association of Cardiovascular and Pulmonary Rehabilitation. *Guidelines for Pulmonary Rehabilitation Programs*. 5th ed. Champaign, IL, Human Kinetics; 2019.
15. Qaseem A, Wilt T, Weinberger S, et al. Diagnosis and management of stable chronic obstructive pulmonary disease: a clinical practice guideline update from the American College of Physicians, American College of Chest Physicians, American Thoracic Society, and European Respiratory Society. *Ann Intern Med*. 2011;155:179-191.

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

Supplemental Digital Content

The topics and findings below were part of the survey beyond the specifics of exercise prescrption.

Oxygen Titration

There was a modest increase in respondents providing oxygen titration during exercise in 2016 vs. 2013 (94.7% vs. 92.7%; $p = 0.302$). 6MWT was added to the 2016 survey as an option for oxygen titration and was the most frequent method used followed by treadmill walking and stationary bicycle. Oxygen systems used during titration showed a modest but non-significant increase in use of the patient's system, continuous and pulse dose systems in 2016 vs. 2013 (Figure 1).

Additional Patient Education Topics

A new question in the 2016 survey asked about patient education topics. In addition to formal exercise classes, over 90% of respondents reported providing educational sessions on oxygen use, prescription, and safety, exacerbation prevention and management, medication management, inhaler and nebulizer use, self-management education, and activities of daily living management and pacing. Fewer reported providing formal education on secretion clearance, dietician counseling, traveling with lung disease, managing panic and mood disorders, and communication with the medical team, with only 66.6% reporting the provision of a class on advanced directives.

Staff Role and Discipline

In the 2016 survey, exercise physiologists (EP) surpassed respiratory therapists (RT) and registered nurses (RN) as the discipline most frequently developing the exercise prescription. In the 2013 survey, RT was most frequent, followed by RN and EP. Over 50% of programs included RT, RN, EP and physicians, with significant increase in EP ($p \leq 0.001$) in 2016 vs. 2013 in their core PR team. Use of RT, physical therapists, physicians, occupational therapists, social workers, dieticians, and psychologists declined non-significantly in 2016 vs. 2013 (see Figure 2). There was an increase in use of EPs developing PR exercise prescriptions. This may reflect the greater emphasis of exercise prescription in EP education and certification vs. other disciplines. There was a decrease in proportion of programs involving occupational therapists, social workers, and psychologists, and physicians and dieticians are lacking in 40 to 50% of the programs, respectively. This trend is concerning given the clinical complexity of patients with chronic lung disease, such as COPD, requiring the involvement of diverse healthcare disciplines. Even though exercise training is the corner stone of improvement in physical performance, varied healthcare disciplines are necessary to improve health-related behaviors.

PR Program Demographics

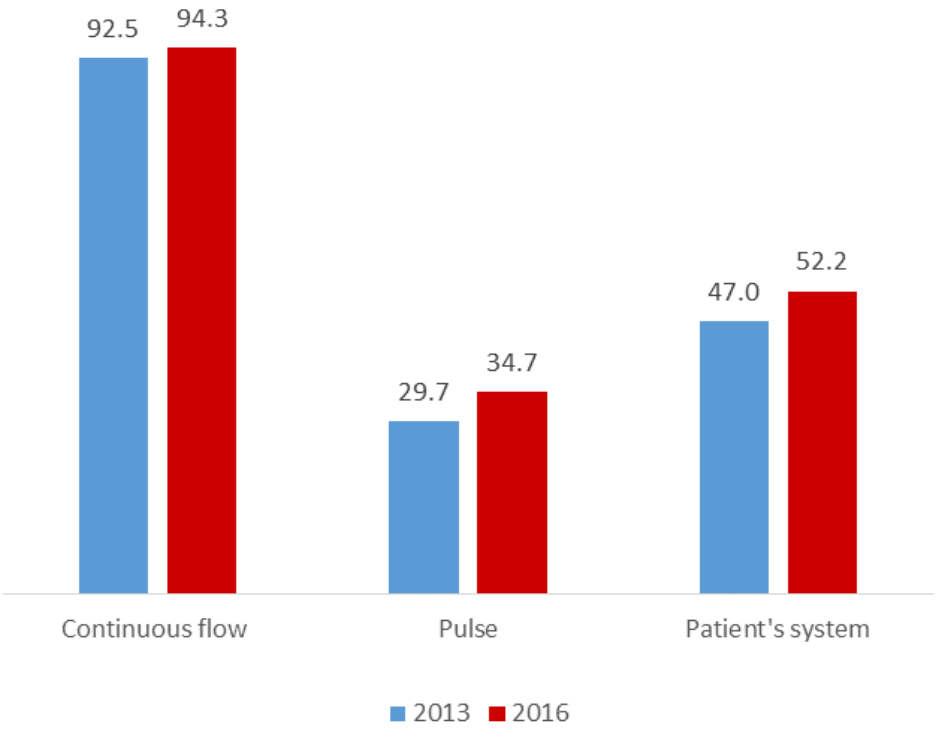
All respondents reported including patients with COPD, with over 80% of programs including patients with interstitial lung disease (e.g., idiopathic pulmonary fibrosis, sarcoid, scleroderma), asthma, and pulmonary hypertension. Fewer programs included neuromuscular disorders (amyotrophic lateral sclerosis, Parkinson's, etc.) and 6.7% included pediatric patients (Figure 3). Other observational trends in the 2016 survey included an increase in programs caring for patients with chest wall abnormalities and thoracic surgery. New patient diagnoses in the 2016 survey included patients immediately post exacerbation and/or hospitalization, pediatric lung diseases and pulmonary hypertension (Figure 3).

Program Size and Setting

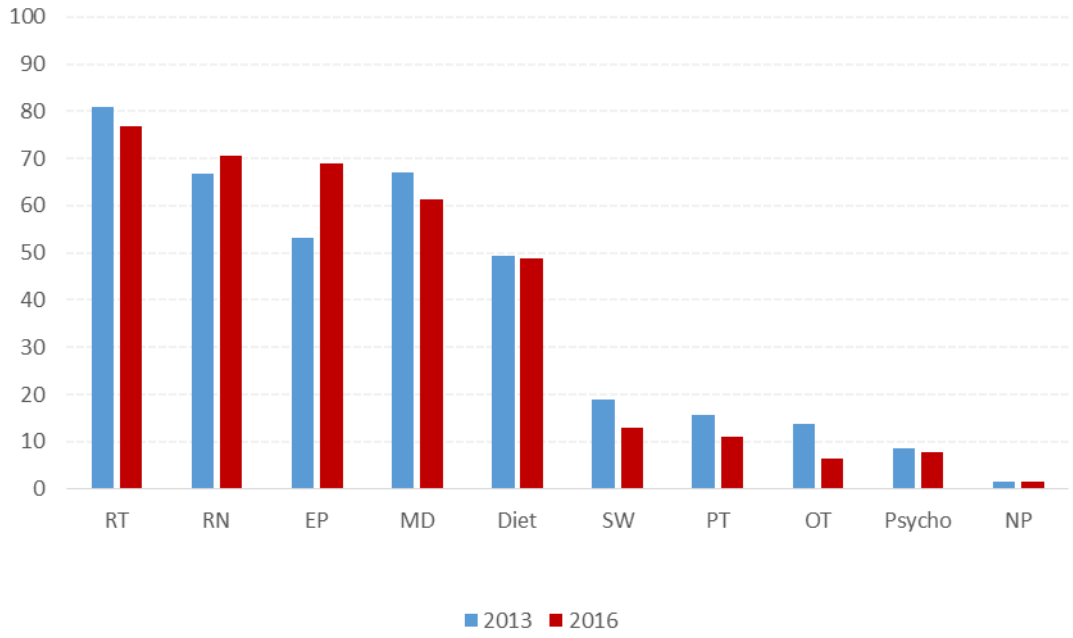
Over 95% of programs identified themselves as hospital based vs. less than 4% as free standing. One percent described their program as having an academic affiliation, with slight non-significant changes compared to 2013. Observations regarding the size of the program based on the number of PR patients (excludes maintenance patients) per year showed an increase in medium and very large size programs vs. the 2013 survey (Figure 4). A new question in 2016 asked about providing PR vs. cardiac rehabilitation (CR) vs. both programs. The vast majority (82.3%) provide both vs. 17.4% PR only and 0.3% CR only. Only two thirds of programs offer training on advance directives. PR patients identify a strong interest in advanced care planning that strongly suggests an important opportunity for PR clinicians to increase provision of this essential component of self-management training.[1]

SDC References

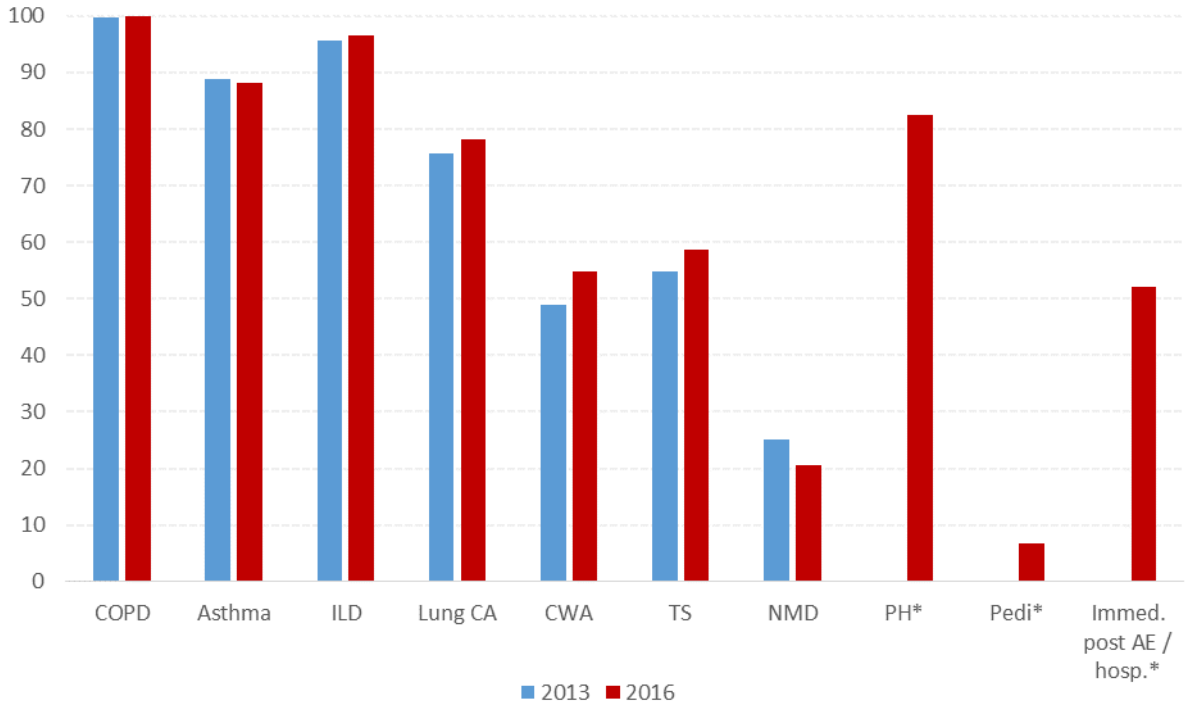
1. Gardiner C, Gott M, Small N, Payne S, Seamark D, Barnes S, Halpin D, Ruse C. Living with advanced chronic obstructive pulmonary disease: patients concerns regarding death and dying. *Palliat Med.* 2009;23:691–697.



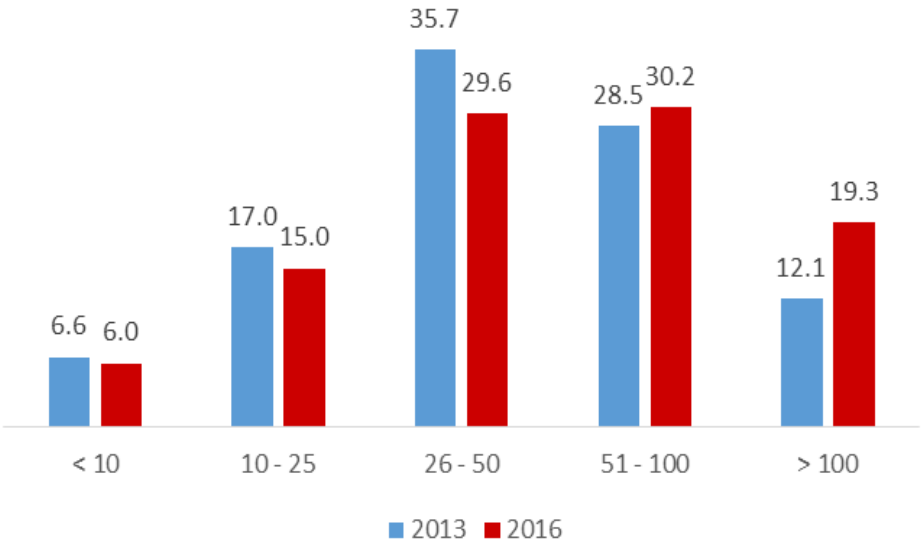
SDC Figure 1: Oxygen system during for titration (expressed in %)
Continuous flow = continuous flow oxygen; Pulse = pulse flow oxygen; Patient's system = patient's ambulatory oxygen system



SDC Figure 2: Staff disciplines in Pulmonary Rehabilitation (expressed in %)
RT = respiratory therapist; RN = registered nurse; EP = exercise physiologist; MD = physician; Diet = dietician; SW = social worker; PT = physical therapist; OT = occupational therapist; Psycho = psychologist; NP = nurse practitioner



SDC Figure 3: Patient's diagnoses in PR Program (expressed in %)
COPD = chronic obstructive pulmonary disease; ILD = interstitial lung disease; Lung CA = lung cancer; CWA = chest wall abnormalities; TS = thoracic surgery; NMD = neuromuscular disorders; PH = pulmonary hypertension; Pedi = pediatric patients; Immed. post AE / hosp. = immediately post-acute exacerbation / hospitalization.
* new for 2016



SDC Figure 4: Total phase II PR patients per year (expressed in %)

SDC Table 1: Summary of oxygen titration, staff disciplines, patient diagnosis, program volume and size.

Question	2013 Survey Results	2016 Survey Results	χ^2	P value
Do you perform oxygen titration during exercise? (2013 n = 313) (2016 n = 318)			**1.065**	**0.302**
Yes	92.7% (290)	94.7% (301)		
No	7.3% (23)	5.3% (17)		
If yes, describe method of exercise used during titration: (2013 n = 196) (2016 n = 265)				
Treadmill	96.0% (188)	23.4% (62)		
Cycle	48.0% (94)	7.5% (20)		
6MWT *(new for 2016)*	N/A	69.1% (183)		
What oxygen system(s) are used? Check all that apply. (2013 n = 279) (2016 n = 297)				
Continuous flow	92.5% (258)	94.3% (280)	0.759	0.384
Pulse	29.7% (83)	34.7% (103)	1.600	0.206
Patient's ambulatory oxygen system	47.0% (131)	52.2% (155)	1.577	0.209
Who develops exercise prescription? Check all that apply. (2013 n = 307) (2016 n = 311)				
RT	57.3% (176)	57.2% (178)	0.001	0.981
RN	45.3% (139)	47.6% (148)	0.332	0.565
ET	44.3% (136)	62.4% (194)	20.294	<0.001
Physician	37.1% (114)	30.5% (95)	2.995	0.084
PT	6.2% (19)	6.1% (19)	0.002	0.967
NP	1.0% (3)	0.3% (1)	1.033	0.310
OT *(new for 2016)*	N/A	1.0% (3)		
Mix of your core PR team members. Check all that apply. (2013 n = 306) (2016 n = 313)				
RT	81.0% (248)	76.7% (240)	1.770	0.183
RN	66.7% (204)	70.6% (221)	1.116	0.291
EP	53.3% (163)	69.0% (216)	16.151	<0.001

Physician	67.0% (205)	61.3% (192)	2.149	0.143
Dietician	49.3% (151)	48.9% (153)	0.013	0.908
Social Worker	19.0% (58)	12.8% (40)	4.427	0.035
PT	15.7% (48)	10.9% (34)	3.133	0.077
OT	13.7% (42)	6.4% (20)	9.238	0.002
Psychologist	8.5% (26)	7.7% (24)	0.143	0.705
NP	1.6% (5)	1.6% (5)	0.001	0.971
Which disorders receive care in your PR program? (2013 n = 305) (2016 n = 312)				
COPD	99.7% (304)	100.0% (312)	1.025	0.311
Asthma	88.9% (271)	88.1% (275)	0.077	0.782
Interstitial lung disease (includes IPF, sarcoid, scleroderma, etc.)	95.7% (292)	96.5% (301)	0.224	0.636
Lung cancer	75.7% (231)	78.2% (244)	0.530	0.467
Chest wall abnormalities (scoliosis, kyphosis, etc.)	48.9% (149)	54.8% (171)	2.191	0.139
Thoracic surgery	54.8% (167)	58.7% (183)	0.956	0.328
Neuromuscular disorders (ALS, Parkinson's, etc.)	25.2% (77)	20.5% (64)	1.960	0.162
Pulmonary hypertension *(new for 2016)*	N/A	82.4% (257)		
Pediatric lung diseases *(new for 2016)*	N/A	6.7% (21)		
Patients immediately post-acute exacerbation and / or hospitalization *(new for 2016)*	N/A	52.2% (163)		
What best describes your PR program? (2013 n = 302) (2016 n = 300)			**0.862**	**0.650**
Hospital-based	94.7% (286)	95.7% (287)		
Free-standing	4.6% (14)	3.3% (10)		

Academic affiliation	0.7% (2)	1.0% (3)		
Approximate number of Phase II patients seen per year? (2013 n = 305) (2016 n = 301)			**8.057**	**0.153**
Less than 10	6.6% (20)	6.0% (18)		
10-25	17.0% (52)	15.0% (45)		
26-50	35.7% (109)	29.6% (89)		
51-100	28.5% (87)	30.2% (91)		
More than 100	12.1% (37)	19.3% (58)		

6MWT = 6 minute walking test; RT = respiratory therapist; RN = registered nurse; EP = exercise physiologist; PT = physical therapist; NP = nurse practitioner; OT = occupational therapist; COPD = chronic obstructive pulmonary disease; IPF = idiopathic pulmonary fibrosis; ALS = amyotrophic lateral sclerosis

SDC Table 2: New questions in 2016 survey

Question	Results survey 2016
Please check the components your program offers beyond exercise training. Check all that apply. (2016 n= 305)	
Oxygen use, prescription, safety	98.4% (300)
Medication management, inhaler and nebulizer use	97.7% (298)
Exacerbation prevention, management	95.7% (292)
Self-management education	93.8% (286)
Activity of Daily Living management, pacing	93.1% (284)
Secretion clearance	88.2% (269)
Dietician counseling	87.2% (266)
Traveling with chronic lung disease	81.6% (249)
Management of panic and mood disorders	81.0% (247)
Communication with the medical team	78.0% (238)
Advance directives	66.6% (203)
Is your program certified as part of the AACVPR Pulmonary Rehabilitation Program Certification? (2016 n = 302)	
Yes	65.2% (197)
No	34.8% (105)
Do you provide: (2016 n = 305)	
Pulmonary Rehabilitation only	17.4% (53)
Cardiac Rehabilitation only	0.3% (1)
Both	82.3% (251)

ISSUE: Outpatient Pulmonary Rehabilitation Services (OPR)

TAB: 23

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99497	XXX	Advance care planning including the explanation and discussion of advance directives such as standard	6	0.039	0.033			1.50			45	5				30			10					
2nd REF	99238	XXX	Hospital discharge day management; 30 minutes or less	5	0.044	0.034			1.28			38	8				20			10					
CURRENT CMS/OTHER	G0424	XXX	Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two		0.024	0.023			0.28			12	2				7			3					
SVY	94625	XXX	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation;	39	0.037	0.029	0.20	0.55	1.00	1.20	20.00	35	10		1	9	15	30	45	10	0	0	10	40	550
REC	94625	XXX	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)		0.031	0.026			0.55			21	2				9			10					

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	94621	XXX	Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production,	6	0.032	0.028			1.42			50	10				30			10					
2nd REF	99231	XXX	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least	5	0.054	0.038			0.76			20	5				10			5					
CURRENT CMS/OTHER	G0424	XXX	Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two		0.024	0.023			0.28			12	2				7			3					
SVY	94626	XXX	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with	39	0.046	0.032	0.35	0.69	1.09	1.53	400.00	34	10		1	9	14	21	50	10	0	0	8	33	400
REC	94626	XXX	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)		0.030	0.027			0.69			26	2				14			10					

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: **January 2021-**
REVISED 1-13-2021

CPT Code	Long Descriptor	Global Period
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session).	XXX
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session) / (do not report 94625, 94626 in conjunction with 94760, 94761).	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
94625	A 67-year-old male with severe chronic obstructive pulmonary disease is enrolled in a pulmonary rehabilitation program without oximetry monitoring 45 days after hospitalization for an exacerbation.
94626	A 67-year-old male with severe chronic obstructive pulmonary disease is enrolled in a pulmonary rehabilitation program with oximetry monitoring 45 days after hospitalization for an exacerbation.

The reason the patient is the same for both CPT codes is to allow for the varying protocols (acceptable following the guidelines referenced later in this document) by the different sites. The use of oximetry continuously monitored is typically site driven rather than patient driven. To explain further, some sites intermittently monitor during the exercise rather than continuous. As per the society guidelines, oximetry would be monitored during these sessions.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   We convened a joint society consensus panel with members from the two participating societies including: American Thoracic Society (ATS) and the American College of Chest Physicians (CHEST)

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   93798 Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session) and 93017 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

No, according to the billed together data in the RUC database, G0424 is billed alone 83 percent of the time and billed with an E/M 1 percent of the time.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

Pulmonary Disease 56 percent of the time

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

CA009 Obtain Vital signs – we are obtaining 4 vital signs, BP, HR, RR and Sp02

CA011 Provide education - as per society guidelines of the American Thoracic Society /European Respiratory Society Statement: Key Concepts and Advances in Pulmonary Rehabilitation https://www.thoracic.org/statements/resources/copd/PRStatementrccm-2E201309-1634st.pdf" https://www.thoracic.org/statements/resources/copd/PRStatementrccm-2E201309-1634st.pdf Education is an integral component of pulmonary rehabilitation programs. There is education provided at each separate session following a curriculum outlined in the guideline and covers the following topics: These are different at each session.

EDUCATIONAL TOPICS CONCERNING SELF-MANAGEMENT
- Normal pulmonary anatomy and physiology
- Pathophysiology of chronic respiratory disease
- Communicating with the health care provider
- Interpretation of medical testing
- Breathing strategies
- Secretion clearance techniques
- Role and rationale for medications, including oxygen therapy
- Effective use of respiratory devices
- Benefits of exercise and physical activities
- Energy conservation during activities of daily living
- Healthy food intake
- Irritant avoidance/smoking cessation
- Early recognition and treatment of exacerbations
- Leisure activities
- Coping with chronic lung disease

EDUCATIONAL TOPICS CONCERNING ADVANCE CARE PLANNING
- Diagnosis and disease process
- Patient autonomy in medical decision-making
- Life-sustaining treatments
- Advance directives documents
- Surrogate decision-making
- Durable powers of attorney for health care
- Discussing advance care planning with health care professionals and family caregivers
- Process of dying
- Prevention of suffering

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Further evidence for adoption of guideline-based exercise prescription methodology is noted in this recent publication from March 2020: Survey of Exercise Prescription in US Pulmonary Rehabilitation Programs. https://journals.lww.com/jcrjournal/Fulltext/2020/03000/Survey_of_Exercise_Prescription_in_US_Pulmonary.13.aspx. Supplemental digital content figure 3, demonstrates that RT is the predominant Staff type in PR programs 75-80% of the time. http://links.lww.com/JCRP/A167

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

The increase is not related to physician time.
These services are new CPT codes. While there is a G code, that code is a CMS other and has not been through the RUC or AMA society participated survey process. Of note the G code and the CPT codes are not the same; the G code describes services for up to two sessions on one day. The CPT code is for the typical comprehensive service that is typically a 90 minute single session with the elements that are outlined in the guidelines that are referenced in this summary.
Since these are both new codes, it is not clear if compelling evidence is necessary, however in case the RUC believes compelling evidence is necessary, then we believe the evidence that the G code was not surveyed by the specialty that provides the service and therefore the CMS data is flawed. We also believe the published guidelines referenced, meet the compelling evidence PE criteria, we reference below the two criteria below from CE that have been met.

1.) "Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in the clinical staff time, supplies and equipment due to one or more of the following:

- technique
- knowledge/technology"
- patient population

See Attachments A, B and C

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

We obtain 4 vital signs, HR BP, RR and Sp02

9. Please provide a brief description of the clinical staff work for the following:
   Pre-Service period:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

a. Service period (includes pre, intra and post):

PRE-SERVICE PERIOD;
Room prep/ situate o2 tanks/pulse oximeters/Position chairs/ review patient's treatment plan
Obtain Vital signs/ BP/HR/RR/Spo2
Education / Interview patient for changes/review plan for the day

INTRA SERVICE PERIOD:
As per society guidelines of the American Thoracic Society /European Respiratory Society Statement: Key Concepts and Advances in Pulmonary Rehabilitation
https://www.thoracic.org/statements/resources/copd/PRStatementrccm-2E201309-1634st.pdf AMERICAN JOURNAL OF RESPIRATORY AND CRITICAL CARE MEDICINE VOL 188 2013
3 Attachments A, B, C for supporting documentation
Individualized programs are developed which integrate various modes of training at each session, encompassing endurance training of both upper and lower extremities, resistance/strength training and flexibility training. Each component will be followed by vitals and an assessment of exercise and dyspnea.
Each session will have the following.
Exercise of lower extremity endurance -20 min
Assess exercise, Sp02, HR, ratings of dyspnea and exertion-5 min
Resistance/Strength – 10min
Assess exercise, Sp02, HR, ratings of dyspnea and exertion-5 min
Exercise of upper extremity endurance- 10 min
Assess exercise, Sp02, HR, ratings of dyspnea and exertion-5 min
Stretching/Flexibility-5 min
Vital signs, HR, BP, Sp02 review day and plan-5 min
Documentation/charting throughout

POST-SERVICE (OF SERVICE PERIOD)
Clean room and equipment

b. Post-service period:

N/A

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

See above

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
    N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
    N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
    N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

N/A

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

N/A

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitude D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code? N/A
    c. Does the computer include code specific software that is typically used to provide the service(s)? N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EQ118	exercise equipment (treadmill, bike, stepper, UBE, pulleys, balance board)

Default formula

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

SK059 was changed to SK057 as the incorrect paper was requested.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**		**RECOMMENDED**	
2						**93798**		**93017**		**G0424**		**94625**		**94626**	
3		***RUC Collaboration Website***				Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation		Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day		Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)		Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): 1/13/21 Tab: 23 Specialty: ATS & CHEST**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**										
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 11.63**	**$ -**	**$ 24.03**	**$ -**	**$ 13.73**	**$ -**	**$ 42.04**	**$ -**	**$ 45.74**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**0.0**	**49.0**	**0.0**	**30.0**	**0.0**	**93.0**	**0.0**	**93.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**0.0**	**44.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L042B	Respiratory Therapist	0.42	**0.0**	**0.0**	**0.0**	**0.0**	**30.0**	**0.0**	**93.0**	**0.0**	**93.0**	**0.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 6.66**	**$ -**	**$ 18.13**	**$ -**	**$ 12.60**	**$ -**	**$ 39.06**	**$ -**	**$ 39.06**	**$ -**
14		**PRE-SERVICE PERIOD**													
15		**Start: Following visit when decision for surgery/procedure made**													
16	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37										
17	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37										
18	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37										
19	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37										
20	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37										
21	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37										
22	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37										
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37			5							
30		**End: When patient enters office/facility for surgery/procedure**													
31		**SERVICE PERIOD**													
32		**Start: When patient enters office/facility for surgery/procedure:**													
33		**Pre-Service (of service period)**													
34	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37	3									
35	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L042B	Respiratory Therapist	0.42							3		3	
36	CA010	Obtain vital signs	L042B	Respiratory Therapist	0.42							5		5	
37	CA011	Provide education/obtain consent	L042B	Respiratory Therapist	0.42							15		15	
38	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37										
39	CA013	Prepare room, equipment and supplies	L042B	Respiratory Therapist	0.42							2		2	
40	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37										
41	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37										
42	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37										
43	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37										
50		**Intra-service (of service period)**													
51	CA018	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37										
52	CA019	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37										
53	CA020	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37										
54	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37	15		44							
57	CA021	Perform procedure/service---NOT directly related to physician work time	L042B	Respiratory Therapist	0.42					30		65		65	
62		**Post-Service (of service period)**													
63	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37										
64	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37										
65	CA024	Clean room/equipment by clinical staff	L042B	Respiratory Therapist	0.42							3		3	
66	CA025	Clean scope	L037D	RN/LPN/MTA	0.37										
67	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37										
68	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37										
69	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37										
70	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37										
71	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37										
72	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37										
73	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37										
74	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37										
75	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs,	L037D	RN/LPN/MTA	0.37										
76	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37										
77	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
78			L037D	RN/LPN/MTA	0.37										
84		**End: Patient leaves office/facility**													
85		**POST-SERVICE PERIOD**													
86		**Start: Patient leaves office/facility**													
87	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37										
88	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37										

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**		**RECOMMENDED**	
2						**93798**		**93017**		**G0424**		**94625**		**94626**	
3		***RUC Collaboration Website***				Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation		Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day		Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)		Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): 1/13/21 Tab: 23 Specialty: ATS & CHEST**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**										
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 11.63**	**$ -**	**$ 24.03**	**$ -**	**$ 13.73**	**$ -**	**$ 42.04**	**$ -**	**$ 45.74**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**0.0**	**49.0**	**0.0**	**30.0**	**0.0**	**93.0**	**0.0**	**93.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**0.0**	**44.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L042B	Respiratory Therapist	0.42	**0.0**	**0.0**	**0.0**	**0.0**	**30.0**	**0.0**	**93.0**	**0.0**	**93.0**	**0.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
102		**End: with last office visit before end of global period**													

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**		**RECOMMENDED**	
2						**93798**		**93017**		**G0424**		**94625**		**94626**	
3		***RUC Collaboration Website***				Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)		Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation		Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day		Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)		Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): 1/13/21 Tab: 23 Specialty: ATS & CHEST**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**										
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**		**XXX**		**XXX**		**XXX**		**XXX**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 11.63**	**$ -**	**$ 24.03**	**$ -**	**$ 13.73**	**$ -**	**$ 42.04**	**$ -**	**$ 45.74**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**0.0**	**49.0**	**0.0**	**30.0**	**0.0**	**93.0**	**0.0**	**93.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**18.0**	**0.0**	**44.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L042B	Respiratory Therapist	0.42	**0.0**	**0.0**	**0.0**	**0.0**	**30.0**	**0.0**	**93.0**	**0.0**	**93.0**	**0.0**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
103	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**											
104		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 1.59**	**$ -**	**$ 2.66**	**$ -**	**$ -**	**$ -**	**$ 0.35**	**$ -**	**$ 3.50**	**$ -**
105	sd053	electrode, ECG (single)	0.0675	item		10		10							
106	sg050	gauze, non-sterile 2in x 2in	0.4233	item		2									
107	sk057	paper, laser printing (each sheet)	0.0163	item		4						**2**		**4**	
108	SK072	sandpaper (per sheet)	0.707	item				1							
109	sk059	paper, recording (per sheet)	0.0617	item				15				**0**		**0**	
110	sj053	swab-pad, alcohol	0.0333	item				1							
111	sg021	bandage, strip 0.75in x 3in (Bandaid)	0.3182	item				1							
112	SM022	sanitizing cloth-wipe (surface, instruments, equipment)	0.064	item								5		6	
114	SD084	gas, oxygen	0.0083	liter										195	
115	SD100	nasal cannula	1.428	item										1	
116															
117	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**										
118		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 3.38**	**$ -**	**$ 3.25**	**$ -**	**$ 1.13**	**$ -**	**$ 2.63**	**$ -**	**$ 3.19**	**$ -**
119	eq243	treadmill	4757.12	Default	0.014208868			46		45					
120	eq211	pulse oximeter w-printer	1858.72	Default	0.005999264					45				93.0	
121	eq009	ECG, 1-channel (Burdick)	1506	Default	0.004860814					45					
122	eq078	cardiac monitor w-treadmill (12-lead PC-based ECG)	21234.195	Default	0.056349746	60		46							
123	EF023	table, exam	3887.8377	Default	0.008648083										
124	EQ118	exercise equipment (treadmill, bike, stepper, UBE, pulleys, balance board)	12710	Default	0.028272047							93.0		93.0	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2021

Remote Therapeutic Monitoring – Tab 24

In October 2020, the CPT Editorial Panel created five new CPT codes to report remote therapeutic monitoring services. Remote physiologic monitoring treatment management services are provided when a physician or qualified health care professional (QHP) and/or clinical staff use the results of remote physiological monitoring to manage a patient under a specific treatment plan.

98980 ***Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes***
The RUC reviewed the survey results from 50 physicians and qualified health care professionals (QHPs) for CPT code 98980 and determined that the survey 25th percentile work RVU of 0.62 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes of intra-service time. The RUC noted that a physician/QHP would not be permitted to report this code if that physician/QHP spent less than 20 minutes performing these services across a given calendar month and that this work would include 2-3 minutes of data review every few days and an interactive communication with the patient once per month. The RUC also discussed the vignette and the fact that the typical patient is an 8-year-old with asthma. The specialty societies noted that only 46 percent of survey respondents found the vignette to be typical. The respondents and the specialty noted the typical patient to be older and have complex medical conditions and co-morbidities, particularly following surgical procedures after which these treatment/monitoring devices would be provided.

The RUC compared CPT code 98980 to the top key reference service CPT code 99457 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes* (work RVU = 0.61, 20 minutes total time) and determined that both services require nearly identical physician work, time and intensity, which supports the RUC recommended work RVU valuation of 98980. The RUC also compared 98980 to CPT code 99422 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes* (work RVU = 0.50, 15 minutes total time) and noted that 98980 requires 5 minutes of additional time because there is considerably more data review and collection associated with 98980 across a period of 30 days, compared with a period of 7 days for 99422. **The RUC recommends a work RVU of 0.62 for CPT code 98980.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

98981 ***Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 46 physicians and qualified health care professionals (QHPs) for CPT code 98981 and determined that the survey 25th percentile work RVU of 0.61 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes of intra-service time. The RUC compared CPT code 98981 to the top key reference service CPT code 99458 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.61, total time 20 minutes) and determined that both services require the same physician work, time and intensity.

The RUC discussed the valuation of key reference services 99457 (work RVU = 0.61) and 99458 (work RVU =0.61) and noted that these key reference services have identical work RVU values. This supports the same relativity between CPT codes 98980 and 98981 being nearly identical. The specialty societies also noted that a typical patient for 98981 is inherently complex and needs additional evaluation and information gathering and that the work associated with this would essentially be identical to that of the base code. **The RUC recommends a work RVU of 0.61 for CPT code 98981.**

New Technology/New Services
CPT codes 98975, 98976, 98977, 98980 and 98981 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The Practice Expense Subcommittee adjusted the CA021 clinical staff time to reflect the typical musculoskeletal patient for CPT code 98975; discussed the leasing/rental fee for the new supply item associated with CPT code 98976; and noted the need for the specialty societies to obtain a paid invoice for the new equipment item for CPT code 98977. **The RUC recommends the direct practice expense inputs as modified** by the Practice Expense Subcommittee. The RUC notes that the specialty societies were unable to obtain a paid invoice for the new equipment item by the date of submission and **recommends that CMS work directly with the specialty societies and others to determine the acquisition costs for the new equipment item *Remote musculoskeletal therapy system.*** CMS has experience with a similar situation where the Agency worked directly with a cardiac device manufacturer to attain the manufacturing costs and other proprietary information for a separate cardiac device.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Non-Face-to-Face Services** **Digitally Stored Data Services/Remote Physiologic Monitoring** *Codes 99453 and 99454 are used to report remote physiologic monitoring services (eg, weight, blood pressure, pulse oximetry) during a 30-day period. To report 99453, 99454, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Code 99453 may be used to report the setup and patient education on use of the device(s). Code 99454 may be used to report supply of the device for daily recording or programmed alert transmissions. Codes 99453, 99454 are not reported if monitoring is less than 16 days. Do not report 99453, 99454 when these services are included in other codes for the duration of time of the physiologic monitoring service (eg, 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring).* *Code 99091 should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation.* *If the services described by 99091 or 99474 are provided on the same day the patient presents for an evaluation and management (E/M) service to the same provider, these services should be considered part of the E/M service and not reported separately.* *Do not report 99091 for time in the same calendar month when used to meet the criteria for care plan oversight services (99374, 99375, 99377, 99378, 99379, 99380), home, domiciliary, or rest home care plan oversight services (99339, 99340), remote physiologic monitoring services (99457, 99458), or personally performed chronic or principal care management (99491, 99437, 99424, 99425,99426, 99427). Do not report 99091 if other more specific codes exist (eg, 93227, 93272 for cardiographic services; 95250 for continuous glucose monitoring). Do not report 99091 for transfer and interpretation of data from hospital or clinical laboratory computers.* *Code 99453 is reported for each episode of care. For coding remote monitoring of physiologic parameters, an episode of care is defined as beginning when the remote monitoring physiologic service is initiated, and ends with attainment of targeted treatment goals.* *#99453 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment*				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(Do not report 99453 more than once per episode of care)

(Do not report 99453 for monitoring of less than 16 days)

#99454 *device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*

(For physiologic monitoring treatment management services, use 99457)

(Do not report 99454 for monitoring of less than 16 days)

(Do not report 99453, 99454 in conjunction with codes for more specific physiologic parameters [eg, 93296, 94760])

(For self-measured blood pressure monitoring, see 99473, 99474)

(For remote therapeutic monitoring, see 98975, 98976, 98977)

#99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days*

(Do not report 99091 in conjunction with 99457, 99458)

(Do not report 99091 ~~if it occurs within 30 days of~~ for time in a calendar month when used to meet the criteria for 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99457, 99487, 99491, 99437, 99424, 99425)

Remote Physiologic Monitoring Treatment Management Services

Remote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan. To report remote physiological monitoring, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Do not use 99457, 99458 for time that can be reported using more specific monitoring services ~~(eg, for the patient that requires reevaluation of medication regimen and/or changes in treatment)~~. Codes 99457, 99458 may be reported during the same service period as chronic care management services (99437, 99439, 99487, 99489, 99490, 99491), principal care management services (99424, 99425, 99426, 99427), transitional care management services (99495, 99496), and behavioral health integration services (99484, 99492, 99493, 99494)~~;~~, ~~h~~However, time spent performing these services should remain separate and no time should be counted twice toward the required time for any~~both~~ services in a single month. Codes 99457, 99458 require a live, interactive communication with the patient/caregiver. For the first completed 20 minutes of clinical staff/physician/other qualified health care professional time in a calendar month report 99457, and report 99458 for each additional completed 20 minutes. Do not report 99457, 99458 for services of less than 20 minutes. Report 99457 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

To report remote therapeutic monitoring treatment management services provided by physician/other qualified health care professional, see 98980, 98981.

Do not count any time on a day when the physician or other qualified health care professional reports an E/M service (office or other outpatient services 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, inpatient services 99221, 99222, 99223, 99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255). Do not count any time related to other reported services (eg, 93290, 93793, 99291, 99292).

#99457 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes*

(Report 99457 once each 30 days, regardless of the number of parameters monitored)

(Do not report 99457 for services of less than 20 minutes)

(Do not report 99457 in conjunction with 93264, 99091)

(Do not report 99457 in the same month as 99473, 99474)

+#99458 *each additional 20 minutes (List separately in addition to code for primary procedure)*

(Use 99458 in conjunction with 99457)

(For remote therapeutic monitoring treatment management services, see 98980, 98981)

~~*(Report only 99457 if you have not completed 20 minutes of additional treatment regardless of time spent)*~~

(Do not report 99458 for services of less than an additional increment of 20 minutes)

Medicine
Non-Face-to-Face Nonphysician Services
Qualified Nonphysician Health Care Professional Online Digital Assessment and Management Service

Qualified nonphysician health care professional online digital assessment and management services are…

98970 *Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

98971 *11-20 minutes*

98972 *21 or more minutes*

(Report 98970, 98971, 98972 once per 7-day period)

(Do not report online digital E/M services for cumulative visit time less than 5 minutes)

(Do not count 98970, 98971, 98972 time otherwise reported with other services)

(Do not report 98970, 98971, 98972 for home and outpatient INR monitoring when reporting 93792, 93793)

(Do not report 98970, 98971, 98972 when using 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99490, 99491, 99426, 99427 for the same communication[s])

Remote Therapeutic Monitoring Services

Remote therapeutic monitoring services (eg, musculoskeletal system status, respiratory system status, therapy adherence, therapy response) represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. These data may represent objective device-generated integrated data or subjective inputs reported by a patient. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.

Codes 98975, 98976, 98977 are used to report remote therapeutic monitoring services during a 30-day period. To report 98975, 98976, 98977 the service must be ordered by a physician or other qualified health care professional. Code 98975 may be used to report the set-up and patient education on use of any device(s) used for therapeutic data collection. Codes 98976, 98977 may be used to report supply of the device for scheduled (eg, daily) recording(s) and/or programmed alert(s) transmissions. To report 98975, 98976, 98977, the device used must be a medical device as defined by the FDA. Codes 98975, 98976, 98977 are not reported if monitoring is less than 16 days. Do not report 98975, 98976, 98977 with other physiologic monitoring services (eg, 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring or 99453, 99454 for remote monitoring of physiologic parameter[s]).

Code 98975 is reported for each episode of care. For reporting remote therapeutic monitoring parameters, an episode of care is defined as beginning when the remote therapeutic monitoring service is initiated and ends with attainment of targeted treatment goals.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

● 98975	AA1	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment (Do not report 98975 more than once per episode of care) (Do not report 98975 for monitoring of less than 16 days)	XXX	0.00 (PE Only)
● 98976	AA2	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	XXX	0.00 (PE Only)
● 98977	AA3	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days (For therapeutic monitoring treatment management services, use 98980) (For physiologic monitoring treatment management services, use 99457) (Do not report 98976, 98977 for monitoring of less than 16 days) (Do not report 98975, 98976, 98977 in conjunction with codes for more specific physiologic parameters [93296, 94760, 99453, 99454]) (For remote physiologic monitoring, see 99453, 99454) (For self-measured blood pressure monitoring, see 99473, 99474)	XXX	0.00 (PE Only)

Remote Therapeutic Monitoring Treatment Management Services

Remote therapeutic monitoring treatment management services are provided when a physician/other qualified health care professional uses the results of remote therapeutic monitoring to manage a patient under a specific treatment plan. To report remote therapeutic monitoring, the service must be ordered by a physician or other qualified health care professional. To report 98980, 98981, any device used must be a medical device as defined by the FDA. Do not use 98980, 98981 for time that can be reported using more specific monitoring services. Codes 98980, 98981 may be reported during the same service period as chronic care management services (99439, 99487, 99489, 99490, 99491), transitional care management services (99495, 99496), *principal care management services (99424, 99425, 99426, 99427)* and behavioral health integration services (99484, 99492, 99493, 99494); however, time spent performing these services should remain separate and no time should

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

be counted toward the required time for both services in a single month. Codes 98980, 98981 require at least one interactive communication with the patient/caregiver. The interactive communication contributes to the total time but need not represent cumulative reported time of the treatment management service. For the first completed 20 minutes of physician/other qualified health care professional time in a calendar month report 98980, and report 98981 for each additional completed 20 minutes. Do not report 98980, 98981 for services of less than 20 minutes. Report 98980 one time regardless of the number of therapeutic monitoring modalities performed in a given calendar month.

Do not count any time on a day when the physician or other qualified health care professional reports an E/M service (office or other outpatient services 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, inpatient services 99221, 99222, 99223, 99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255).

Do not count any time related to other reported services (eg, psychotherapy services 90832, 90833, 90834, 90836, 90837, 90838, interrogation device evaluation services 93290, anticoagulant management services 93793, respiratory monitoring services 94774, 94775, 94776, 94777, health behavior assessment and intervention services 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96160, 96161, 96170, 96171, therapeutic interventions that focus on cognitive function services 97129, 97130, adaptive behavior treatment services 97153, 97154, 97155, 97156, 97157, 97158, therapeutic activities 97530, physical therapy evaluation services 97161, 97162, 97163, 97164, occupational therapy evaluations 97165, 97166, 97167, 97168, orthotic management and training and prosthetic training services 97760, 97661, 97763, medical nutrition therapy services 97802, 97803, 97804, medication therapy management services 99605, 99606, 99607, critical care services 99291, 99292, *principal care management services 99424, 99425, 99426, 99427*) in the cumulative time of the remote therapeutic monitoring treatment management service during the calendar month of reporting.

● 98980	AA4	Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes (Report 98980 once each 30 days, regardless of the number of therapeutic parameters monitored) (Do not report 98980 for services of less than 20 minutes) (Do not report 98980 in conjunction with 93264, 99091, 99457, 99458) (Do not report 98980 in the same calendar month as 99473, 99474)	XXX	0.62
✚● 98981	AA5	each additional 20 minutes (List separately in addition to code for primary procedure)	ZZZ	0.61

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		(Use 98981 in conjunction with 98980) (Do not report 98981 for services of less than an additional increment of 20 minutes)		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:98980 Tracking Number AA4 Original Specialty Recommended RVU: **0.62**
Presented Recommended RVU: **0.62**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.62**

CPT Descriptor: Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring.

Percentage of Survey Respondents who found Vignette to be Typical: 46%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Physician or QHP analyzes and interprets the data. Based on the interpreted data, the physician/QHP uses medical/clinical decision making to assess the patient's condition, communicate with the patient, and oversee, coordinate, and/or modify the patient's care through shared decision making in order to achieve established outcomes/goals of care.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021		
Presenter(s):	Carlo Milani, MD; David Reece, DO; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Richard Rausch, PT, DPT; Steven Krug, MD		
Specialty Society(ies):	AAPM&R; ANA; APTA; AAP		
CPT Code:	98980		
Sample Size:	7314	**Resp N:**	50
Description of Sample:	Each society selected a random sample of US physician or QHP members: AAPM&R (1,000), AAP (1,000), APTA (4,343), and AAN (971).		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	10.00	1200.00
Survey RVW:	0.48	0.62	**0.97**	1.00	65.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	15.00	**20.00**	20.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	98980	**Recommended Physician Work RVU: 0.62**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99457	XXX	0.61	**RUC Time**

CPT Descriptor Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99442	XXX	0.97	**RUC Time**

CPT Descriptor Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion (Note: the Work RVU listed is the 2020 Work RVU value).

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95251	XXX	0.70	**RUC Time**	248,288

CPT Descriptor 1 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	10,729,531

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source

0.00

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 24.0 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 24.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 98980	Top Key Reference CPT Code: 99457	2nd Key Reference CPT Code: 99442
Median Pre-Service Time	0.00	0.00	5.00
Median Intra-Service Time	20.00	20.00	20.00
Median Immediate Post-service Time	0.00	0.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**20.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	58%	42%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required		67%	33%
Physical effort required	8%	67%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	58%	34%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	50%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	42%	33%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	59%	33%
Physical effort required	33%	50%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	58%	42%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

An expert panel of providers from each of the participating specialty societies (ie, AAPM&R, ANA, APTA, AAP) reviewed and discussed survey results for the Remote Therapeutic Monitoring (RTM) codes (98980 and 98981).

98980
We are recommending the **median intraservice time** (20 minutes). This code is reported for the first completed 20 minutes of physician/other qualified health care professional time in a calendar month. The expert panel agreed that the median time of 20 minutes was appropriate and properly aligned with the intraservice/total time for 99457 (20 minutes) which was one of the two key reference services.

We also are recommending the survey **25th percentile work relative value units** (wRVU) of 0.62. This value places this code in proper rank order to 99457 as well as to the key reference services.

98981
We are recommending the **median intraservice time** (20 minutes). This code is reported for each additional completed 20 minutes in a calendar month. The expert panel agreed that the median time of 20 minutes was appropriate and properly aligned with the intraservice/total time for 99458 (20 minutes) which was the top key reference service.

We also are recommending the survey **25th percentile work relative value units** (wRVU) of 0.61. This value places this code in proper rank order to 99458 as well as to the key reference services.

While the median Service Performance Rate for this code was zero, we believe that the number of responses received and the data for both codes was sufficient to support making a recommendation to the RUC.

Key Reference Services
Service Performance Rates

KRS #1: 99458
Low: 0
25th: 0
Median: 12
75th: 47
High: 1200

KRS #2: G0506
Low: 0
25th: 0
Median: 1
75th: 18
High: 1200

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A This is a new service

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Physical Medicine & Rehabilitation How often? Sometimes

Specialty Nurse Practitioner How often? Commonly

Specialty Physical Therapy How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 60000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare claims for 99457

Specialty Physical Medicine & Rehabilitation Frequency 20000 Percentage 33.33 %

Specialty Nurse Practitioner Frequency 20000 Percentage 33.33 %

Specialty Physical Therapy Frequency 20000 Percentage 33.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 50,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2019 Medicare claims for 99457

Specialty Physical Medicine & Rehabilitation Frequency 16500 Percentage 33.00 %

Specialty Nurse Practitioner Frequency 16500 Percentage 33.00 %

Specialty Physical Therapy Frequency 16500 Percentage 33.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Tests

BETOS Sub-classification:

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20553

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:98981 Tracking Number AA5 Original Specialty Recommended RVU: **0.61**
Presented Recommended RVU: **0.61**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **0.61**

CPT Descriptor: Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month;each additional 20 minutes (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring. Note: This is an add-on service. Only consider the additional work related to the additional physician or QHP staff time beyond the 20 minutes reported with 98980.

Percentage of Survey Respondents who found Vignette to be Typical: 48%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Physician or QHP analyzes and interprets the data. Based on the interpreted data, the physician/QHP uses medical/clinical decision making to assess the patient's condition, communicate with the patient, and oversee, coordinate, and/or modify the patient's care through shared decision making in order to achieve established outcomes/goals of care. Additional time is needed due to the specific needs of the patient's medical condition(s).

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Carlo Milani, MD; David Reece, DO; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Richard Rausch, PT, DPT; Steven Krug, MD					
Specialty Society(ies):	AAPM&R; ANA; APTA; AAP					
CPT Code:	98981					
Sample Size:	7314	**Resp N:**	46			
Description of Sample:	Each society selected a random sample of US physician or QHP members: AAPM&R (1,000), AAP (1,000), APTA (4,343), and AAN (971).					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**0.00**	10.00	1200.00
Survey RVW:		0.50	0.61	**0.73**	0.97	23.00
Pre-Service Evaluation Time:				**0.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		5.00	14.00	**20.00**	24.00	45.00
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	98981	**Recommended Physician Work RVU: 0.61**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99458	ZZZ	0.61	**RUC Time**

CPT Descriptor Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0506	ZZZ	0.87	**CMS Time File**

CPT Descriptor Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20552	000	0.66	**RUC Time**	350,677

CPT Descriptor 1 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77002	ZZZ	0.54	**RUC Time**	528,759

CPT Descriptor 2 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 28 **% of respondents:** 60.8 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 26.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 98981	Top Key Reference CPT Code: 99458	2nd Key Reference CPT Code: G0506
Median Pre-Service Time	0.00	0.00	5.00
Median Intra-Service Time	20.00	20.00	16.00
Median Immediate Post-service Time	0.00	0.00	7.50
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**20.00**	**28.50**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	64%	29%	3%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	50%	36%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	68%	21%
Physical effort required	29%	57%	14%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	53%	36%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	42%	50%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	42%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	50%	42%
Physical effort required	33%	50%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	33%	59%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

An expert panel of providers from each of the participating specialty societies (ie, AAPM&R, ANA, APTA, AAP) reviewed and discussed survey results for the Remote Therapeutic Monitoring (RTM) codes (989 and 98981).

98980
We are recommending the **median intraservice time** (20 minutes). This code is reported for the first completed 20 minutes of physician/other qualified health care professional time in a calendar month. The expert panel agreed that the

median time of 20 minutes was appropriate and properly aligned with the intraservice/total time for 99457 (20 minutes) which was one of the two key reference services.

We also are recommending the survey **25th percentile work relative value units** (wRVU) of 0.62. This value places this code in proper rank order to 99457 as well as to the key reference services.

98981
We are recommending the **median intraservice time** (20 minutes). This code is reported for each additional completed 20 minutes in a calendar month. The expert panel agreed that the median time of 20 minutes was appropriate and properly aligned with the intraservice/total time for 99458 (20 minutes) which was the top key reference service.

We also are recommending the survey **25th percentile work relative value units** (wRVU) of 0.61. This value places this code in proper rank order to 99458 as well as to the key reference services.

While the median Service Performance Rate for this code was zero, we believe that the number of responses received and the data for both codes was sufficient to support making a recommendation to the RUC.

Key Reference Services
Service Performance Rates

KRS #1: 99458
Low: 0
25th: 0
Median: 12
75th: 47
High: 1200

KRS #2: G0506
Low: 0
25th: 0
Median: 1
75th: 18
High: 1200

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A This is a new service

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Physical Medicine & Rehabilitation How often? Sometimes

Specialty Nurse Practitioner How often? Commonly

Specialty Physical Therapy How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 40000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Two-thirds of the estimate for 98980

Specialty Physical Medicine & Rehabilitation Frequency 13333 Percentage 33.33 %

Specialty Nurse Practitioner Frequency 13333 Percentage 33.33 %

Specialty Physical Therapy Frequency 13333 Percentage 33.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 33,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Two-thirds of the estimate for 98980

Specialty Physical Medicine & Rehabilitation Frequency 11000 Percentage 33.33 %

Specialty Nurse Practitioner Frequency 11000 Percentage 33.33 %

Specialty Physical Therapy Frequency 11000 Percentage 33.33 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Tests

BETOS Sub-classification:
Other tests

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20553

SS Rec Summary

ISSUE: Remote Therapeutic Monitoring

TAB: 24

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99457	XXX	Remote physiologic monitoring treatment management	12	0.031	0.031			0.61			20						20								
2nd REF 2020	99442	XXX	Telephone evaluation and management service by a	12	0.037	0.032			0.97			30	5					20			5					
SVY	98980	XXX	Remote therapeutic monitoring treatment, physician/other	50	0.049	0.049	0.48	0.62	0.97	1.00	65.00	20				1	15	20	20	35		0	0	1	10	1200
REC	98980	XXX	Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar		0.031	0.031			0.62			20						20								

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99458	ZZZ	Remote physiologic monitoring treatment management	28	0.031	0.031			0.61			20						20								
2nd REF	G0506	ZZZ	Comprehensive assessment of and care planning for patients	12	0.037	0.031			0.87			28.5	5					16			7.5					
SPR More Than Zero	98981	ZZZ	Remote therapeutic monitoring treatment, physician/other	22	0.037	0.037	0.50	0.61	0.73	0.99	20.00	20				8	15	20	26	45		1	5	10	20	1200
SPR Zero	98981	ZZZ	Remote therapeutic monitoring treatment, physician/other	24	0.038	0.038	0.50	0.61	0.73	0.97	23.00	19				5	12	19	21	30		0	0	0	0	0
SVY	98981	ZZZ	Remote therapeutic monitoring treatment, physician/other	46	0.037	0.037	0.50	0.61	0.73	0.97	23.00	20				5	14	20	24	45		0	0	0	10	1200
REC	98981	ZZZ	Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)		0.031	0.031			0.61			20						20								

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 98975**

SPECIALTY SOCIETY(IES):_AAP, AAPM&R, ANA, APTA

PRESENTER(S):_Carlo Milani, MD; David Reece, DO; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, RNFA; Richard Rausch, PT, DPT; Steven Krug, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	XXX
98976	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	XXX
98977	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	XXX
98980	Remote therapeutic monitoring treatment management services, physician/ other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes	XXX
98981	Remote therapeutic monitoring treatment management services, physician/ other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
98975	A 65-year-old male presents to the physician's or other qualified health care professional's office with exacerbation of a chronic condition. Following the visit, the physician initiates a remote therapeutic monitoring program to enable data collection and monitoring to support therapeutic management.
98976	An 8-year-old female presents to the physician's or other qualified health care professional's office with cough and wheezing. She is diagnosed with a respiratory condition exacerbated by environmental factors. Following the visit, the physician or other qualified health care professional initiates a remote therapeutic monitoring program to enable data collection and monitoring to support therapeutic management of her respiratory condition.
98977	A 66-year-old female who has limited mobility caused by osteoarthritis of her knees is enrolled in a remote therapeutic monitoring program to enable data collection and monitoring to support treatment management of her musculoskeletal condition.
98980	An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring.

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 98975**

SPECIALTY SOCIETY(IES):_AAP, AAPM&R, ANA, APTA

PRESENTER(S):_Carlo Milani, MD; David Reece, DO; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, RNFA; Richard Rausch, PT, DPT; Steven Krug, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

98981	An 8-year-old presents to the physician's or other qualified health care professional's office with exacerbation of asthma. The physician or other qualified health care professional initiates a remote therapeutic monitoring program to support therapeutic management through data collection and monitoring. Note: This is an add-on service. Only consider the additional work related to the additional physician or QHP staff time beyond the 20 minutes reported with 98980.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The practice expense recommendations for codes 98975 were determined through email dialogue amongst our Specialty Society RVS Committee Expert Panel. Our panel was comprised of the advisors and alternate advisors from the participating specialties. The panel reviewed existing practice expense inputs the remote physiological monitoring codes (99453, 99454, 99457 and 99458). Further, the societies contacted representatives from two remote therapeutic monitoring technology companies: specifically, Aria (formerly VERA), which produces a musculoskeletal system monitoring device and Propeller Health which produces a respiratory system monitoring device. Both companies provided receipt information as well as insights into staff time related to their technologies. This information was taken into consideration as recommendations were developed.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

Reference for 98975 - 99453 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), intial; set-up and patient education on use of equipment

Reference for 98976 and 98977 – Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

Reference for 98980 – Remote physiologic monitoring treatment management services, clinical staff/ physician/ other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

Reference for 98981 – Remote physiologic monitoring treatment management services, clinical staff/ physician/ other qualified health professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes

The remote physiologic monitoring (RPM) code family was used as a reference in the development of our recommendations for this code family. This was due to the remote therapeutic codes being modeled, with some variations, after the RPM codes in structure. The RPM codes are reflective of similar staff work though the specific equipment is different.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)
   New code

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)
   New code

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
   Not applicable

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:
   Not applicable

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:
   Not applicable

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:
   Not applicable as vital signs are not taken for this code.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

   b. Service period (includes pre, intra and post):
   98975 - Clinical staff greets the patient and reviews medical records to confirm service. Clinical staff conducts set up of the technology and educates the patient regarding its use.

   98980 and 98981 – Clinical staff reviews therapeutic monitoring data with the physician. Data outside of expected norms

   c. Post-service period:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

98975 - Clinical staff contacts the patient following the encounter to ensure the technology is working and that the patient is on track to complete their daily tasks related to therapeutic monitoring.

98980 and 98981 – Clinical staff conducts patient communications throughout the month to improve therapy adherence, address lack of improvement/control of condition, and resolve any technology or data transmission concerns.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

98975 - Clinical staff walks the patient through set up of the therapeutic monitoring technology. The patient is educated regarding how to use the technology and related daily tasks. For respiratory therapy monitoring, this includes introduction to the device as well as mobile app. For musculoskeletal therapy monitoring, this includes set up of the device, review of the 3D motion capture technology, and review of the specific exercises as prescribed by the physician/QHP. The patient is given the opportunity to ask questions.

98980 and 98981 – Clinical staff reviews the therapeutic monitoring data with the physician/QHP. Areas in which data reflects poor control of condition or deviation from expected treatment adherence are identified. This data review is typically done on a weekly basis throughout the 30 days.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

Not applicable.

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

Not applicable.

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

Not applicable

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

Propeller Health invoice for $300 documenting the leasing of the Bluetooth sensors (2 provided in each rental) placed on top of the patient's inhalers (typically 1 daily use inhaler and 1 rescue inhaler) as well as use of the app technology for tracking. This is included in line 102 of the spreadsheet as a monthly rental price of $25. The useful life of this technology is 1 year as the sensors are replaced after 1 year.

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

The only supply used is the new supply described in question 16.

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Line 113 – remote musculoskeletal therapy system uses the monitoring equipment formula, however no staff time is associated with this code.

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Crosswalk for 98975 is 99453 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), intial; set-up and patient education on use of equipment

Crosswalk for 98976 and 98977 is 99454 - Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, oximetry, respiratory flow rate), device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	K	L	N
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFEREN**
2						**CPT Code 99453**		**CPT Code 98975**		**CPT Co**
3		***RUC Collaboration Website***				Remote monitoring of physiologic parameter(s) (eg, weight, blood		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal		Remote m physi paramet weight
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 24 Specialty: AAP, AAPM&R, ANA, APTA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 12.21**	**$ -**	**$ 17.76**	**$ -**	**$ 48.85**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**33.0**	**0.0**	**48.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**30.0**	**0.0**	**38.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**0.0**	**10.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 12.21**	**$ -**	**$ 17.76**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37					
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37					
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37					
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37					
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37					
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37					
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37					
23			L037D	RN/LPN/MTA	0.37					
26		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37	3		3		
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37					
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37					
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37					
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37					
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37					
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37					
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37					
42			L037D	RN/LPN/MTA	0.37					
45		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
48		**Intra-service (of service period)**								
49	CA018	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37					
50	CA019	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37					
51	CA020	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37	27		35		
55			L037D	RN/LPN/MTA	0.37					
56		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37					
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37					
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37					
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37					
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37					
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37					
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37					
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and decon cons	L037D	RN/LPN/MTA	0.37					
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	L037D	RN/LPN/MTA	0.37					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37					
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, ECG file, etc.)	L037D	RN/LPN/MTA	0.37					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37					
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a		n/a		n/a
75			L037D	RN/LPN/MTA	0.37					
78		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37	3		10		
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37					
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27							
89		99213 36 minutes	36							
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37					
96		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	K	L	N
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFEREN**
2						**CPT Code 99453**		**CPT Code 98975**		**CPT Co**
3		***RUC Collaboration Website***				Remote monitoring of physiologic parameter(s) (eg, weight, blood		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal		Remote m physi paramet weight
4	**Clinical Activity Code**	**Meeting Date: January 2021 Revision Date (if applicable): Tab: 24 Specialty: AAP, AAPM&R, ANA, APTA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 12.21**	**$ -**	**$ 17.76**	**$ -**	**$ 48.85**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**33.0**	**0.0**	**48.0**	**0.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**30.0**	**0.0**	**38.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**0.0**	**10.0**	**0.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102	New	Remote respiratory therapy system	25	monthly rental						
103										
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ 48.85**
112	EQ392	heart failure patient physiologic monitoring equipment package	1000		0.001130764					43200
113	New	Remote musculoskeletal therapy system		Monitoring						
114										
115										
116										
117										
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	O	P	Q	R	S	U	V	W	X
1	RUC Practice Expense Spreadsheet		CE CODE	RECOMMENDED		RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2			de 99454	CPT Code 98976		CPT Code 98977		CPT Code 99457		CPT Code 98980	
3		*RUC Collaboration Website*		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy		Remote physiologic monitoring treatment management services, clinical staff/		Remote therapeutic monitoring treatment management services, physician/ other qualified health	
4	Clinical Activity Code	Meeting Date: January 2021 Revision Date (if applicable): Tab: 24 Specialty: AAP, AAPM&R, ANA, APTA	onitoring of biologic er(s) (eg, blood								
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ 25.00	$ -	$ -	$ -	$ 14.80	$ -	$ 14.80	$ -
8		TOTAL CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	40.0	0.0	40.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	10.0	0.0	10.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	30.0	0.0	30.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ 14.80	$ -	$ 14.80	$ -
13		PRE-SERVICE PERIOD									
14		Start: Following visit when decision for surgery/procedure made									
15	CA001	Complete pre-service diagnostic and referral forms									
16	CA002	Coordinate pre-surgery services (including test results)									
17	CA003	Schedule space and equipment in facility									
18	CA004	Provide pre-service education/obtain consent									
19	CA005	Complete pre-procedure phone calls and prescription									
20	CA006	Confirm availability of prior images/studies									
21	CA007	Review patient clinical extant information and questionnaire									
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)									
23											
26		*Other activity: please include short clinical description here and type new in column A*									
29		End: When patient enters office/facility for surgery/procedure									
30		SERVICE PERIOD									
31		Start: When patient enters office/facility for surgery/procedure:									
32		Pre-Service (of service period)									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are [illegible]									
34	CA010	Obtain vital signs									
35	CA011	Provide education/obtain consent									
36	CA012	Review requisition, assess for special needs									
37	CA013	Prepare room, equipment and supplies									
38	CA014	Confirm order, protocol exam									
39	CA015	Setup scope (nonfacility setting only)									
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient									
41	CA017	Sedate/apply anesthesia									
42											
45		*Other activity: please include short clinical description here and type new in column A*									
48		Intra-service (of service period)									
49	CA018	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)									
50	CA019	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)									
51	CA020	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)									
52	CA021	Perform procedure/service---NOT directly related to physician work time						10		10	
55											
56		*Other activity: please include short clinical description here and type new in column A*									
59		Post-Service (of service period)									
60	CA022	Monitor patient following procedure/service, multitasking 1:4									
61	CA023	Monitor patient following procedure/service, no multitasking									
62	CA024	Clean room/equipment by clinical staff									
63	CA025	Clean scope									
64	CA026	Clean surgical instrument package									
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions									
66	CA028	Review/read post-procedure x-ray, lab and pathology reports									
67	CA029	Check dressings, catheters, wounds									
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page									
69	CA031	Review examination with interpreting MD/DO									
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue									
71	CA033	Perform regulatory mandated quality assurance activity (service period)									
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, ECG file, etc.)									
73	CA035	Review home care instructions, coordinate visits/prescriptions									
74	CA036	Discharge day management		n/a		n/a		n/a		n/a	
75											
78		*Other activity: please include short clinical description here and type new in column A*									
81		End: Patient leaves office/facility									
82		POST-SERVICE PERIOD									
83		Start: Patient leaves office/facility									
84	CA037	Conduct patient communications						30		30	
85	CA038	Coordinate post-procedure services									
86		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
87		99211 16 minutes									
88		99212 27 minutes									
89		99213 36 minutes									
90		99214 53 minutes									
91		99215 63 minutes									
92	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
93											
96		*Other activity: please include short clinical description here and type new in column A*									
99		End: with last office visit before end of global period									

	A	B	O	P	Q	R	S	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**CE CODE**	**RECOMMENDED**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2			**de 99454**	**CPT Code 98976**		**CPT Code 98977**		**CPT Code 99457**		**CPT Code 98980**	
3		***RUC Collaboration Website***		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal		Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy		Remote physiologic monitoring treatment management services, clinical staff/		Remote therapeutic monitoring treatment management services, physician/ other qualified health	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 24** **Specialty: AAP, AAPM&R, ANA, APTA**	onitoring of ologic er(s) (eg, , blood								
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 25.00**	**$ -**	**$ -**	**$ -**	**$ 14.80**	**$ -**	**$ 14.80**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**40.0**	**0.0**	**40.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**10.0**	**0.0**	**10.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**30.0**	**0.0**	**30.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**									
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ 25.00**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102	New	Remote respiratory therapy system		1							
103											
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
110	**Equipment Code**	**EQUIPMENT**									
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112	EQ392	heart failure patient physiologic monitoring equipment package									
113	New	Remote musculoskeletal therapy system				43200					
114											
115											
116											
117											
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	Z	AA	AB	AC
1	**RUC Practice Expense Spreadsheet**		**REFERENCE CODE**		**RECOMMENDED**	
2			**CPT Code 99458**		**CPT Code 98981**	
3		***RUC Collaboration Website***	Remote physiologic monitoring treatment management services, clinical staff/		Remote therapeutic monitoring treatment management services, physician/ other qualified health	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 24** **Specialty: AAP, AAPM&R, ANA, APTA**				
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 7.40**	**$ -**	**$ 7.40**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**20.0**	**0.0**	**20.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**10.0**	**0.0**	**10.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**10.0**	**0.0**	**10.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 7.40**	**$ -**	**$ 7.40**	**$ -**
13		**PRE-SERVICE PERIOD**				
14		**Start: Following visit when decision for surgery/procedure made**				
15	CA001	Complete pre-service diagnostic and referral forms				
16	CA002	Coordinate pre-surgery services (including test results)				
17	CA003	Schedule space and equipment in facility				
18	CA004	Provide pre-service education/obtain consent				
19	CA005	Complete pre-procedure phone calls and prescription				
20	CA006	Confirm availability of prior images/studies				
21	CA007	Review patient clinical extant information and questionnaire				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)				
23						
26		*Other activity: please include short clinical description here and type new in column A*				
29		**End: When patient enters office/facility for surgery/procedure**				
30		**SERVICE PERIOD**				
31		**Start: When patient enters office/facility for surgery/procedure:**				
32		**Pre-Service (of service period)**				
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available				
34	CA010	Obtain vital signs				
35	CA011	Provide education/obtain consent				
36	CA012	Review requisition, assess for special needs				
37	CA013	Prepare room, equipment and supplies				
38	CA014	Confirm order, protocol exam				
39	CA015	Setup scope (nonfacility setting only)				
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient				
41	CA017	Sedate/apply anesthesia				
42						
45		*Other activity: please include short clinical description here and type new in column A*				
48		**Intra-service (of service period)**				
49	CA018	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)				
50	CA019	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)				
51	CA020	Assist physician of other qualified healthcare professional---directly related to physician work time (other %)				
52	CA021	Perform procedure/service---NOT directly related to physician work time	10		10	
55						
56		*Other activity: please include short clinical description here and type new in column A*				
59		**Post-Service (of service period)**				
60	CA022	Monitor patient following procedure/service, multitasking 1:4				
61	CA023	Monitor patient following procedure/service, no multitasking				
62	CA024	Clean room/equipment by clinical staff				
63	CA025	Clean scope				
64	CA026	Clean surgical instrument package				
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions				
66	CA028	Review/read post-procedure x-ray, lab and pathology reports				
67	CA029	Check dressings, catheters, wounds				
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page				
69	CA031	Review examination with interpreting MD/DO				
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue				
71	CA033	Perform regulatory mandated quality assurance activity (service period)				
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)				
73	CA035	Review home care instructions, coordinate visits/prescriptions				
74	CA036	Discharge day management	n/a		n/a	
75						
78		*Other activity: please include short clinical description here and type new in column A*				
81		**End: Patient leaves office/facility**				
82		**POST-SERVICE PERIOD**				
83		**Start: Patient leaves office/facility**				
84	CA037	Conduct patient communications	10		10	
85	CA038	Coordinate post-procedure services				
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes				
88		99212 27 minutes				
89		99213 36 minutes				
90		99214 53 minutes				
91		99215 63 minutes				
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**
93						
96		*Other activity: please include short clinical description here and type new in column A*				
99		**End: with last office visit before end of global period**				

	A	B	Z	AA	AB	AC
1	**RUC Practice Expense Spreadsheet**		**REFERENCE CODE**		**RECOMMENDED**	
2			**CPT Code 99458**		**CPT Code 98981**	
3		***RUC Collaboration Website***	Remote physiologic monitoring treatment management services, clinical staff/		Remote therapeutic monitoring treatment management services, physician/ other qualified health	
4	**Clinical Activity Code**	**Meeting Date: January 2021** **Revision Date (if applicable):** **Tab: 24** **Specialty: AAP, AAPM&R, ANA, APTA**				
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 7.40**	**$ -**	**$ 7.40**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**20.0**	**0.0**	**20.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**10.0**	**0.0**	**10.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**10.0**	**0.0**	**10.0**	**0.0**
100	**Supply Code**	**MEDICAL SUPPLIES**				
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**
102	New	Remote respiratory therapy system				
103						
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*				
110	**Equipment Code**	**EQUIPMENT**				
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**
112	EQ392	heart failure patient physiologic monitoring equipment package				
113	New	Remote musculoskeletal therapy system				
114						
115						
116						
117						
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*				

American Occupational Therapy Association

December 21, 2020

Peter K. Smith, MD
Chair, AMA/Specialty Society RVS Update committee
Relative Value Systems, American Medical Association
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611

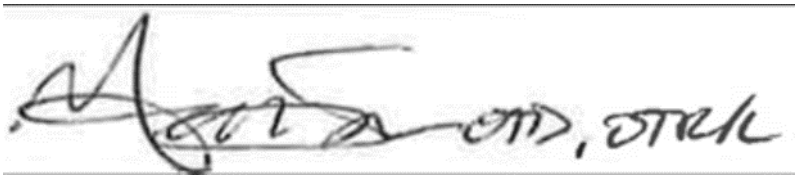
Dear Dr. Smith,

The American Occupational Therapy Association is interested in the new CPT codes for remote therapeutic monitoring as it was surveyed by a related specialty and has relevance to our membership. AOTA's RUC advisors met, reviewed the recommendation, and respectfully submit the following comments.

AOTA is generally supportive of the Remote Therapeutic Monitoring submission. We agree with the selection of key reference services used in the survey. AOTA agrees with the practice expense inputs, but wonders if a valid purchase invoice should be submitted. AOTA noticed that respondents appeared to be lacking experience with the service.

Thank you for the opportunity to comment.

Sincerely,



Katie Jordan, OTD, OTR/L, FAOTA
Primary RUC Advisor

ASHA
American
Speech-Language-Hearing
Association

January 4, 2021

Peter K. Smith, MD
Chair, AMA/Specialty Society RVS Update Committee Relative Value Systems
American Medical Association
330 N. Wabash Ave.
Suite 39300
Chicago, IL 60611

Re: Tab 24 – Remote Therapeutic Monitoring (98975, 98980, and 98981)

Dear Dr. Smith:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the specialty society recommendations for codes **98975**, *remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment***; 98980**, *remote therapeutic monitoring treatment management services, physician/ other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes*; and **98981**, *each additional 20 minutes.*

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 211,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

A small subset of audiologists and speech-language pathologists may report codes 98975, 98980, and 98981, to remotely monitor the progress of treatment for certain hearing, communication, and swallowing disorders, such as tinnitus and dysphagia. As such, ASHA's advisors and Health Care Economics Committee reviewed the recommendations put forth by the submitting specialty societies. For codes **98980 and 98981,** we agree the 25th percentile work RVU and median intra-service times are appropriate and align well with the key reference service codes. ASHA also agrees with the practice expense inputs for **98975**, **98980, and 98981**. The recommended clinical staff times align with the remote physiologic monitoring reference codes, which were also used as a model for the structure of the new codes. **Therefore, ASHA fully supports the work and practice expense recommendations for codes 98975, 98980, and 98981**

Thank you for the opportunity to offer comments on the recommendations for remote therapeutic monitoring. If you or AMA staff have any questions, please contact Neela Swanson, ASHA's director of health care policy for coding and reimbursement, at nswanson@ash.org.

Sincerely,

Leisha R Eiten

Leisha R. Eiten, AuD, CCC-A
ASHA RUC HCPAC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
New Technology/ New Services

January 2021

Principal Care Management and Chronic Care Management – Tab 25

In September 2019, the CPT Editorial Panel created add-on code 99439 and in January 2020, the RUC made an interim recommendation. At that time, the RUC noted that the specialty societies were developing a CPT coding change application (CCA) to establish principal care management codes and CPT codes 99490, 99439, 99491, 99487 and 99489 would be resurveyed as part of this family of services. Additionally, in October 2020, the RUC flagged CPT codes 99487-99490 via the New Technology/New Services screen. The Relativity Assessment Workgroup reviewed the most recent years of available Medicare claims data (2017, 2018 and preliminary 2019 data) and the RUC recommended these services be surveyed for January 2021, along with the principal care management codes considered at the October 2020 CPT meeting. In October 2020, the CPT Editorial Panel created a new subsection within the Evaluation and Management (E/M) section to identify Principal Care Management (PCM) and to describe principal care management services for management of a single high-risk disease.

CHRONIC CARE MANAGEMENT (CCM)

Compelling Evidence

Chronic care management (CCM) has significantly increased in complexity because complex medical conditions can now more often be managed while the patient is at home instead of during face-to-face services. For example, services to patients with heart failure, diabetes, and autoimmune disorders can be provided by, or under the supervision of, a physician or other qualified health care professional (QHP) while the patient is at home to decrease emergency department visits, hospitalizations, and placement in nursing homes and to improve quality of life. This shift occurred before the COVID-19 public health emergency (PHE), was accelerated by the COVID-19 PHE, and will continue after the COVID-19 PHE.

The rapid evolution of sophisticated tools such as remote monitoring apps, patient portals, self-management apps and the ability for patients to transmit complex data (e.g., high resolution photographs) in real time has increased the ability to provide CCM to patients, since it is primarily a non-face-to-face service. Development of robust remote monitoring technologies (e.g., measurement of pulmonary artery pressures via permanently implanted sensors, continuous monitoring of vital signs by sensors that can transmit data over the internet in real-time) also enables clinicians to make diagnoses and alter treatment regimens without needing to see a patient face-to-face.

Clinicians can now often stratify patients according to risk using CCM so they have time to properly care for those patients who require office visits. This can mean some patients are now contacted daily instead of weekly. The need to recognize and treat mental health issues has also increased as growing evidence demonstrates that psychosocial issues play a major role in the treatment of chronic disease and contact with family members and caregivers is essential to help keep these patients functional and able to live at home.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Regarding patient communication, data from the Washington University School of Medicine in St. Louis tracking portal over the last four years indicates the numbers of users and logins annually has increased significantly. In 2017, they reported just over 403,000 logins with over 44,000 users. Only two years later in 2019, the logins had increased by 17-fold from 403,000 logins to 6.8 million. Likewise, individual users increased more than six times to over 297,000. Additionally, not only did the number of users increase, but the average login per user more than doubled from nine to 22 during that same time. This translates to a significant increase in data entry and information to review for each patient and this is consistent with practices around the country.

Examples of information shared via patient portals and other methods of electronic communication include messages from case managers, family members, caregivers, and patients who submit information with questions about financial barriers to care, need for durable medical equipment, medication confusion, forms and letter requests. In addition, there is more data to review through this technology. Interoperability of medical records, while undoubtedly facilitating the exchange of information, also increases the amount of data to review in a way that simply did not exist in the past.

In summary, the complexity of CCM has significantly increased since the codes were established and last reviewed by the RUC. The RUC agreed there is compelling evidence that there has been a change in knowledge/technology and patient population for CCM and CCCM services.

CCM Services

These services are reported per calendar month with codes differentiated based on the amount of time spent by either the physician personal or by the clinical staff under physician supervision, whichever is greater. The specialty societies indicated that at the beginning of the month, it is not known whether the physician/QHP or the clinical staff will be dedicating greater time to the individual patient management activities. Therefore, the cumulative time and who is performing each of those activities, whether it is clinical staff or whether it is the QHP personally, must be tracked. Regardless of whether the QHP codes or the clinical staff codes are used, there is QHP work taking place. For example, the codes with greater clinical staff time require QHP supervision of the clinical staff. When the QHP personal code is used, there are clinical staff specific activities.

For example, some practices utilize their electronic medical record (EMR) for CCM documentation, which includes a time calculator. The physician submits the management time and indicates whether they as the provider are directly providing that care management with the patient or if the clinical staff is providing this under his/her supervision. It is always assumed clinical staff time is supervised by the QHP. For many patients, the QHP and clinical staff may not meet the calendar month time threshold to report these services, so they do not report them. Therefore, it is only a subset of the patients for whom the threshold is met and the codes reported. At the end of the month a report is generated that indicates which patients have met a certain time threshold, divided out by clinical staff and QHP. Additionally, all the exclusion time will be examined. For instance, time for E/M services on the same date as management services are excluded. There are a series of exclusions to make sure time is not double counted and that time is included on the monthly report. Only after review of the time collated by the report does the QHP determine those which patients might be potentially eligible to report these services, determine and verify that they consented to the services and have a care plan. Only then can the QHP report these services. Smaller practices might count their time on a spreadsheet, whereas others have more sophisticated time counters that are embedded within their EMR.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CCM Clinical Staff Services

99490 ***Chronic care management services … first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 84 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work.

The RUC compared the surveyed code to the second top reference code 99497 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate* (work RVU = 1.50, 30 minutes intra-service time and 45 minutes total time), noting that the surveyed code requires less physician time and work to perform.

For additional support, the RUC referenced codes 99486 *Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU = 1.30 and 25 minutes total time) as this ZZZ service requires the same physician time and similar physician work. **The RUC recommends a work RVU of 1.00 for CPT code 99490.**

99439 ***Chronic care management services … each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure).***
The RUC reviewed the survey responses from 75 physicians and other QHPs and determined the survey 25th percentile work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 20 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work. The RUC agreed that code 99439 was in the proper rank order with base code 99490.

The RUC compared the surveyed code to the top two reference codes 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient…*(work RVU = 0.76, 10 minutes intra-service time and 20 minutes total time) and 99457 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes* (work RVU = 0.61 and 20 minutes total time), which requires identical time and similar physician work. CPT code 99439 is slightly more intense than 99457, due to the sicker patient population receiving CCM services, having two or more chronic conditions and the QHP is using a care plan to manage the patient. **The RUC recommends a work RVU of 0.70 for CPT code 99439.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CCM Physician/QHP Services

99491 ***Chronic care management services… first 30 minutes, provided personally by a physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 55 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 33 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work.

The RUC compared the surveyed code to the second top key reference code 99239 *Hospital discharge day management; more than 30 minutes* (work RVU = 1.90, 30 minutes intra-service time and 55 minutes total time), noting CPT code 99491 requires less physician work and time than 99239, thus is in the proper rank order.

For additional support, the RUC referenced MPC code 99309 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.55 and 45 minutes total time), code 99493 *Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional,…* (work RVU = 2.05 and 36 minutes total time), and code 99498 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure*) (work RVU = 1.40 and 30 minutes total time). **The RUC recommends a work RVU of 1.50 for CPT code 99491.**

99437 ***Chronic care management services… each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 48 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time.

The RUC compared the surveyed code to the second top key reference service 99498 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU = 1.40 and 30 minutes total time), which requires the same physician time but more physician work than 99437. The RUC agreed that is appropriate considering that 99498 is a care planning service that is reported when there are family disagreements and multiple family members with whom discussion is needed.

For additional support, the RUC referenced MPC code 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.16 and 31 minutes total time). **The RUC recommends a work RVU of 1.00 for CPT code 99437.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

COMPLEX CHRONIC CARE MANAGEMENT (CCCM)

99487 ***Complex chronic care management services… first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 51 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.81 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work.

The RUC compared the surveyed code to the second top key reference service 99226 *Subsequent observation care, per day, for the evaluation and management of a patient* (work RVU = 2.00, 30 minutes intra-service time and 55 minutes total time), which requires more total physician time and work than 99487, thus is valued appropriately.

For additional support, the RUC referenced MPC code 99235 *Domiciliary or rest home visit for the evaluation and management of an established patient* (work RVU = 1.72 and 44 minutes total time) and 99239 *Hospital discharge day management; more than 30 minutes* (work RVU = 1.90 and 55 minutes total time). **The RUC recommends a work RVU of 1.81 for CPT code 99487.**

99489 ***Complex chronic care management services… each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 51 physicians and other QHPs and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC noted the physician time for this service has increased, thus validating the increase in physician work.

The RUC compared the surveyed code to the second top key reference service 99457 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes* (work RVU = 0.61 and 20 minutes total time). The RUC determined that 99489 was in the appropriate rank order based on the intensity, physician work and physician time compared to these services.

For additional support, the RUC referenced MPC code 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.16 and 31 minutes total time). **The RUC recommends a work RVU of 1.00 for CPT code 99489.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

PRINICPAL CARE MANAGEMENT (PCM)

Compelling Evidence

For 2020, CMS created two G codes for principal care management G2064 *Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities* (work RVU = 1.45) and G2065 *Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities* (work RVU = 0.61), both of which were crosswalked to existing CCM codes 99491 and 99490, respectively. There was no survey conducted and no review by the RUC for these services. The RUC agreed that there is compelling evidence that a flawed mechanism or methodology was used in the previous valuation of the G codes.

In October 2020, the CPT Editorial Panel created four new codes for principal care management (PCM). Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP. The PCM codes differ from the CCM codes in that they are to be reported by physicians or other QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses.

Physician/QHP PCM

99424 ***Principal care management services, for a single high-risk disease… first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.***

The RUC reviewed the survey responses from 53 physicians and determined the survey 25th percentile work RVU of 1.45 appropriately accounts for the work required to perform this service. The RUC recommends 32 minutes intra-service time. The RUC noted this is in the proper rank order with the recommended work RVU of 1.50 for CPT code 99491 *CCM services by the physician/QHP, first 30 minutes per calendar month*. The principal care management codes are for one single-high risk condition. However, the intensity of managing that high-risk condition is comparable and perhaps higher than managing multiple less urgent, less high-risk chronic conditions.

The RUC compared the surveyed code to the top key reference service 99226 *Subsequent observation care, per day, for the evaluation and management of a patient* (work RVU = 2.00, 30 minutes intra-service time and 55 minutes total time). The RUC agreed that 99424 is valued appropriately compared to this key reference service as 99226 requires almost the same intra-service time but more total time and overall physician work to perform.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

For additional support, the RUC referenced MPC codes 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient…* (work RVU = 1.39 and 40 minutes total time) and 99309 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.55 and 45 minutes total time). **The RUC recommends a work RVU of 1.45 for CPT code 99424.**

99425 ***Principal care management services, for a single high-risk disease… additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 47 physicians and determined the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC agreed that 99425 is a less intense service than base code 99424. The RUC also agreed that the physician work, time and intensity of CPT code 99425 is the same as CPT code 99437 the add-on code for QHP CCM.

The RUC compared the surveyed code to the second key reference code 99498 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU = 1.40 and 30 minutes total time). The RUC agreed that 99498 requires the same physician time but more physician work and intensity than 99425, which is appropriate considering that 99498 is a care planning service that is reported when there are family disagreements and multiple family members with whom discussion is needed.

For additional support, the RUC referenced MPC code 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.16 and 31 minutes total time). **The RUC recommends a work RVU of 1.00 for CPT code 99425.**

Clinical Staff PCM

99426 ***Principal care management services, for a single high-risk disease… first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.***
The RUC reviewed the survey responses from 53 physicians and determined the survey 25th percentile work RVU of 1.10 was too high and would place it out of rank order with physician work and time required for CPT code 99490 *Chronic care management services… first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.* Therefore, the RUC recommends a work RVU of 1.00 for CPT code 99426, a crosswalk to CPT 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU = 1.00 and 25 minutes total time). The RUC recommends 25 minutes intra-service time for CPT code 99426.

The RUC compared the surveyed code to the second top key reference service 99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days* (work RVU = 1.10, 30 minutes intra-service time and 40 minutes total time), noting that the reference code requires more physician time and is less intense than 99426, which involves direct patient care for patients with a deteriorating medical condition over a period of one month.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

For additional support, the RUC referenced MPC codes 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient…* (work RVU = 1.16 and 31 minutes total time) and 99282 *Emergency department visit for the evaluation and management of a patient…* (work RVU = 0.93 and 19 minutes total time). **The RUC recommends a work RVU of 1.00 for CPT code 99426.**

99427 ***Principal care management services, for a single high-risk disease… each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 51 physicians and determined the survey 25th percentile work RVU of 0.91 was too high and would place it out of rank order with the physician time and work required to perform CPT code 99439 *Chronic care management services … each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure.* Therefore, the RUC recommends a work RVU of 0.71 for CPT code 99427, a crosswalk to CPT 95887 *Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)* (work RVU = 0.71 and 20 minutes total time). The RUC recommends 20 minutes intra-service time.

The RUC compared the surveyed code to the second top key reference service 99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days* (work RVU = 1.10, 30 minutes intra-service time and 40 minutes total time), noting 99091 requires more physician time though is less intense than 99427, which involves direct patient care for patients with a deteriorating medical condition over a period of one month.

For additional support, the RUC referenced MPC code 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient…* (work RVU = 0.76 and 20 minutes total time). **The RUC recommends a work RVU of 0.71 for CPT code 99427.**

Practice Expense
The Practice Expense subcommittee determined that there is compelling evidence that technology and patient/ provider knowledge has changed for the CCM services. The Practice Expense Subcommittee noted that the specialty societies were unable to obtain clinical staff time survey responses for the CCM and PCM services and therefore the recommendations were provided by the specialty societies' expert panel. The Practice Expense Subcommittee voted on a revised spreadsheet with increased minutes for CA021 *Perform procedure/service---NOT directly related to physician work time*. Modifying the CCM codes by increasing the clinical staff time by 25% and the clinical staff times for PCM services to reflect the minimum times to report each service. **The RUC recommends the direct practice expense inputs as modified by the specialty societies.** The PE Subcommittee noted that when these codes come back as part of the New Technology/New Services screen, the specialty societies should conduct a clinical staff survey.

G Code Deletion
The RUC recommends that CMS delete G2064 and G2065 as these services may now be reported with CPT codes 99424, 99425, 99426 and 99427.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

New Technology/New Services
CPT codes 99424-99427 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services**				
99339		*Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month;15-29 minutes*		
99340		*30 minutes or more*		
		(Do not report 99339, 99340 for patients under the care of a home health agency, enrolled in a hospice program, or for nursing facility residents) (Do not report 99339, 99340 during the same month with 99439, 99487, 99489, 99490, 99439, 99491, 99437, 99424, 99425, 99426, 99427)		
Prolonged Services **Prolonged Service Without Direct Patient Contact**				
		Codes 99358 and 99359 are used when a prolonged service is provided that is neither face-to-face time in the outpatient, inpatient, or observation setting, nor additional unit/floor time in the hospital or nursing facility setting. Codes 99358, 99359 may be used during the same session of an evaluation and management service, except office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). For prolonged total time in addition to office or other outpatient services (ie, 99205, 99215) on the same date of service without direct patient contact, use 99417. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to face encounter.		
		This service is to be reported . . .		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Code 99358 and 99359 are used . . .

Prolonged service of less than 30 minutes . . .

Code 99359 is used . . .

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Do not report 99358, 99359 for time without direct patient contact reported in other services such as care plan oversight services (99339, 99340, 99374-99380), chronic care management by a physician or other qualified health care professional (99491), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), interprofessional telephone/Internet/electronic health record consultations (99446, 99447, 99448, 99449, 99451, 99452), online digital evaluation and management services (99421, 99422, 99423) or Principal Care Management services (99424).

99358 ***Prolonged evaluation and management service*** *before and/or after direct patient care; first hour*

+99359 *each additional 30 minutes (List separately in addition to code for prolonged service)*

(Use 99359 in conjunction with 99358)

(Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99417)

Case Management Services
Medical Team Conferences
Medical Team Conference, Direct (Face-to-Face) Contact With Patient and/or Family

99366 ***Medical team conference*** *with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional*

(Team conference services of less than 30 minutes duration are not reported separately)

(For team conference services by a physician with patient and/or family present, see Evaluation and Management services)

(Do not report 99366 during the same month with 99439, 99487, 99489, 99490, 99491, 99437, 99424, 99425, 99426, 99427)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Medical Team Conference, Without Direct (Face-to-Face) Contact With Patient and/or Family

99367 ***Medical team conference*** *with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician*

99368 *participation by nonphysician qualified health care professional*

(Team conference services of less than 30 minutes duration are not reported separately)

(Do not report 99367, 99368 during the same month with 99439, 99487, 99489, 99490, 99491, 99437, 99424, 99425, 99426, 99427)

Care Plan Oversight Services

Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility or domiciliary, or non-face-to-face services. The complexity and approximate time of the care plan oversight services provided within a 30-day period determine code selection. Only one individual may report services for a given period of time, to reflect the sole or predominant supervisory role with a particular patient. These codes should not be reported for supervision of patients in nursing facilities or under the care of home health agencies unless they require recurrent supervision of therapy.

The work involved in providing . . .

(For care plan oversight services . . .

(Do not report 99374-99380 for time reported with 98966, 98967, 98968, 99421, 99422, 99423, 99441, 99442, 99443)

(Do not report 99374-99378 during the same month with 99487, 99489)

Non-Face-to-Face Services

Online Digital Evaluation and Management Services

Online digital evaluation and management (E/M) services . . .

. . .

#99421 *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days;5-10 minutes*

#99422 *11-20 minutes*

#99423 *21 or more minutes*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(Report 99421, 99422, 99423 once per 7-day period)

(Clinical staff time is not calculated as part of cumulative time for 99421, 99422, 99423)

(Do not report online digital E/M services for cumulative service time less than 5 minutes)

(Do not count 99421, 99422, 99423 time otherwise reported with other services)

(Do not report 99421, 99422, 99423 on a day when the physician or other qualified health care professional reports E/M services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245])

(Do not report 99421, 99422, 99423 when using 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99437, 99424, 99425, 99426, 99427,-99495, 99496 for the same communication[s])

(Do not report 99421, 99422, 99423 for home and outpatient INR monitoring when reporting 93792, 93793)

(99444 has been deleted. To report, see 99421, 99422, 99423)

Digitally Stored Data Services/Remote Physiologic Monitoring

Codes 99453 and 99454 are used to report remote physiologic monitoring services (eg, weight, blood pressure, pulse oximetry) during a 30-day period. To report 99453, 99454, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Code 99453 may be used to report the set-up and patient education on use of the device(s). Code 99454 may be used to report supply of the device for daily recording or programmed alert transmissions. Codes 99453, 99454 are not reported if monitoring is less than 16 days. Do not report 99453, 99454 when these services are included in other codes for the duration of time of the physiologic monitoring service (eg, 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring).

Code 99091 should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation.

If the services described by 99091 or 99474 are provided on the same day the patient presents for an evaluation and management (E/M) service to the same provider, these services should be considered part of the E/M service and not reported separately.

Do not report 99091 for time in the same calendar month when used to meet the criteria for care plan oversight services (99374, 99375, 99377, 99378, 99379, 99380), home, domiciliary, or rest home care plan oversight services (99339, 99340), remote physiologic monitoring services (99457, 99458), or personally performed chronic or principal care management (99491, 99437, 99424, 99425). Do not report 99091 if other more specific codes exist (eg, 93227, 93272 for cardiographic services; 95250 for continuous glucose monitoring). Do not report 99091 for transfer and interpretation of data from hospital or clinical laboratory computers.

Code 99453 is reported for each episode ...

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

#99453	*Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment*
#99454	*device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*
	(For physiologic monitoring treatment management services, use 99457)
	(Do not report 99454 for monitoring of less than 16 days)
	(Do not report 99453, 99454 in conjunction with codes for more specific physiologic parameters [eg, 93296, 94760])
	(For self-measured blood pressure monitoring, see 99473, 99474)
	(For remote therapeutic monitoring, see 989X1, 989X2, 989X3)
#99091	*Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days*
	(Do not report 99091 in conjunction with 99457)
	(Do not report 99091 for time in a calendar month when used to meet the criteria for 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99457, 99487, 99491, 99437, 99424, 99425)
#99473	*Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration*
	(Do not report 99473 more than once per device)
	(For ambulatory blood pressure monitoring, see 93784, 93786, 93788, 93790)
#99474	*separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient*
	(Do not report 99473, 99474 in the same calendar month as 93784, 93786, 93788, 93790, 99091, 99439, 99453, 99454, 99457, 99487, 99489, 99490, 99491, 99437, 99424, 99425, 99426, 99427)
	(Do not report 99474 more than once per calendar month)

Remote Physiologic Monitoring Treatment Management Services

Remote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan. To report remote physiological monitoring, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Do not use 99457, 99458 for time that can be reported using more specific monitoring services ~~(eg, for~~

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

~~the patient that requires reevaluation of medication regimen and/or changes in treatment)~~. Codes 99457, 99458 may be reported during the same service period as chronic care management services (99439, 99487, 99489, 99490, 99491, 99437), principal care management services (99424, 99425, 99426, 99427), transitional care management services (99495, 99496), and behavioral health integration services (99484, 99492, 99493, 99494)~~;~~. ~~h~~However, time spent performing these services should remain separate and no time should be counted twice toward the required time for any~~both~~ services in a single month. Codes 99457, 99458 require a live, interactive communication with the patient/caregiver. For the first completed 20 minutes of clinical staff/physician/other qualified health care professional time in a calendar month report 99457, and report 99458 for each additional completed 20 minutes. Do not report 99457, 99458 services of less than 20 minutes. Report 99457 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month.

To report remote therapeutic monitoring treatment management services provided by physician/other qualified health care professional, see 989X4, 989X5.

Do not count any time on a day when the physician or other qualified health care professional reports an E/M service (office or other outpatient services 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, inpatient services 99221, 99222, 99223, 99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255). Do not count any time related to other reported services (eg, 93290, 93793, 99291, 99292).

Care Management Services

Care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, or may be provided personally by a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. Care management services improve care coordination, reduce avoidable hospital services, improve patient engagement, and decrease care fragmentation. The physician or other qualified health care professional provides or oversees the management and/or coordination of care management services, which include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. ~~as needed, for all medical conditions, psychosocial needs, and activities of daily living.~~

There are three general categories of care management services: chronic care management (99490, 99439, 99491, 99437), complex chronic care management (99487, 99489) and principal care management (99424, 99425, 99426, 99427). Complex chronic care management addresses all of the patient's medical conditions, and principal care management services address a single condition. Each of the three categories is further subdivided into those services which are personally performed by the physician or other qualified health care professional and those services which are performed by the clinical staff and overseen by the physician or other qualified health care professional. Code selection for these services is based upon time in a calendar month, and time used in reporting these services may not represent time spent in another reported service. Chronic care management services do not require moderate or high-level medical decision making and may be reported for a shorter time threshold than complex chronic care management services. Both chronic care and complex chronic care management address, as needed,

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

all medical conditions, psychosocial needs, and activities of daily living. Principal care management services are disease specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other qualified health care professional is providing single disease rather than comprehensive care management.

Coding Tip

If the treating physician or other qualified health care professional personally performs any of the care management services and those activities are not used to meet the criteria for a separately reported code (99491, 99424), then his or her time may be counted toward the required clinical staff time to meet the elements of 99490, 99487, 99426, as applicable.

Care Planning

A ~~comprehensive~~ plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation. It is intended to provide a simple and concise overview of the patient, and his or her medical condition(s) and be a useful resource for patients, caregivers, health care professionals, and others, as necessary.

A typical plan of care is not limited to, but may include:

- *Problem list*
- *Expected outcome and prognosis*
- *Measurable treatment goals*
- *Cognitive assessment*
- *Functional assessment*
- *Symptom management*
- *Planned interventions*
- *Medical management*
- *Environmental evaluation*
- *Caregiver assessment*
- Interaction and coordination with outside resources and ~~other~~ health care professionals and others, as necessary
- *Summary of advance directives*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The above elements are intended to be a guide for creating a meaningful plan of care rather than a strict set of requirements, so each should be addressed only as appropriate for the individual.

The plan of care should include specific and achievable goals for each condition relevant to the patient's well-being and lifestyle. When possible, the treatment goals should also be measurable and time bound. The plan should be updated periodically based on status or goals changes. The entire care plan should be reviewed or revised as needed but at least annually.

An electronic and/or printed plan of care must be documented and shared with the patient and/or caregiver.

Codes 99487, 99490, 99491, 99437, 99424, 99425, 99426, and 99427 are reported only once per calendar month. Code 99439 is reported no more than twice per calendar month. Code 99439, 99487, 99489, 99490, 99491, 99437 may only be reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month. Codes 99424, 99425, 99426, 99427 may be reported by different physicians or qualified healthcare professionals in the same calendar month for the same patient, and documentation in the patient's medical record should reflect coordination among relevant managing clinicians.

For 99439, 99487, 99489, 99490, 99426, 99427 the face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals, and agencies; creating, revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month. Only the time of the clinical staff of the reporting professional is counted and additionally the reporting professional's time is included if he or she is not otherwise reporting his or her care management time with another service (see Coding Tip). Only count the time of one clinical staff member or physician or qualified health care professional when two or more are meeting about the patient at the same time. For 99491, 99437, 99424, 99425 only count the time personally spent by the physician or other qualified health care professional. Time spent by the physician or other qualified health care professional that does not meet the threshold to report 99491, 99437, 99424, 99425 may be used toward the time necessary to report 99439, 99490, 99487, 99489, 99426, 99427. Do not count ~~any of the~~ clinical staff time spent as part of a separately reported service ~~on the day of an initiating visit (the creation of the care plan, initial explanation to the patient and/or caregiver, and obtaining consent)~~.

Care management activities performed by clinical staff, or personally by the physician or other qualified health care professional, typically include:

- *communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;*
- *communication with home health agencies and other community services utilized by the patient;*
- *collection of health outcomes data and registry documentation;*
- *patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;*
- *assessment and support for treatment regimen adherence and medication management;*
- *identification of available community and health resources;*
- *facilitating access to care and services needed by the patient and/or family;*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

- *management of care transitions not reported as part of transitional care management (99495, 99496);*
- *ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;*
- development, communication, and maintenance of a comprehensive or disease specific (as applicable) care plan.

The care management office/practice must have the following capabilities:

- *provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week;*
- *provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;*
- *provide timely access and management for follow-up after an emergency department visit or facility discharge;*
- utilize an electronic health record system for ~~so that care providers have~~ timely access to clinical information;
- ~~use a standardized methodology to identify patients who require care management services;~~
- ~~have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;~~
- ~~use a form and format in the medical record that is standardized within the practice;~~
- be able to engage and educate patients and caregivers as well as coordinate and integrate care among all service professionals, as appropriate for each patient.
- *reporting physician or other qualified health care professional oversees activities of the care team;*
- *all care team members providing services are clinically integrated.*

Each minute of service time is counted toward only one service. Do not count any time and activities used to meet criteria for another reported service. However, time of clinical staff and time of a physician or other qualified health care professional are ~~distinct~~ reported separately when each provides ~~a~~ distinct, ~~separately reportable~~ service**s** to the same patient at different times during the same ~~period of time (eg,~~ calendar month~~)~~. A list of services not reported in the same calendar month as 99439, 99487, 99489, 99490 is provided in the parenthetical instructions following the care management codes ~~99439, 99489. See the parenthetical instruction below 99491 for a list of services not separately reported in the same calendar month that 99491 is reported. Do not report 99439, 99487, 99489, 99490, when reporting 99491 for the same calendar month.~~ If the care management services are performed within the postoperative period of a reported surgery, the same individual may not report 99439, 99487, 99489, 99490, 99491. ~~For service time used for reporting 99439, 99487, 99489, 99490, 99491, do not also include service time used to report 99421, 99422, 99423.~~

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

~~Care management may be reported in any calendar month during which the clinical staff time or physician or other qualified health care professional personal time requirements are met.~~

When behavioral or psychiatric collaborative care management services are also provided, 99484, 99492, 99493, 99494 may be reported in addition.

Chronic Care Management Services

Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities. Code 994939 is reported in conjunction with 99490 for each additional 20 minutes of clinical staff time spent in care management activities during the calendar month up to a maximum of 60 minutes total time (ie, 99439 may only be reported twice per calendar month). Code 99491 is reported for at least ~~when~~ 30 minutes of physician or other qualified health care professional ~~personal~~ time personally ~~is~~ spent in care management ~~activities~~during the calendar month. Code 99437 is reported in conjunction with 99491 for each additional minimum 30 minutes of physician or other qualified health care professional time. ~~Do not report 99439, 99490 in the same calendar month as 99491.~~ If reporting 99491, 99437, do not ~~count~~ include any time devoted to the patient and/or family on the date that the reporting physician or other qualified health care professional time ~~on the date of~~ also performed a face-to-face E/M encounter ~~towards the time used in reporting 99491~~.

(f)99490	BB5	Chronic care management services, with the following required elements: • multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; • chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; • comprehensive care plan established, implemented, revised, or monitored~~.~~: first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	XXX	1.00
(f)✚99439	BB6	each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure)	ZZZ	0.70

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

<table>
<tr>
<td></td>
<td></td>
<td>(Use 99439 in conjunction with 99490)

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

(Chronic care management services of 60 minutes or more and requiring moderate or high complexity medical decision making may be reported using 99487, 99489)

(Do not report 99439 more than twice per calendar month)

(Do not report 99439, 99490, in the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99491, 99437, 99424, 99425, 99426, 99427, 99605, 99606, 99607)

(Do not report 99439, 99490 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607)

<table>
<tr><th><s>Total Duration of Staff Care Management Services</s></th><th><s>Chronic Care Management</s></th></tr>
<tr><td><s>Less than 20 minutes</s></td><td><s>Not reported separately</s></td></tr>
<tr><td><s>20 to 39 minutes</s></td><td><s>99490 X 1</s></td></tr>
<tr><td><s>40 – 59 minutes</s></td><td><s>99490 X 1 and 99439 X 1</s></td></tr>
<tr><td><s>60 minutes or more (1 hour or more)</s></td><td><s>99490 X 1 and 99439 X 2 (see also 99487)</s></td></tr>
</table>
</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f)99491</td>
<td>BB7</td>
<td>Chronic care management services<s>, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month,</s> with the following required elements:

• multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient<s>;</s>,
• chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline<s>;</s>,</td>
<td>XXX</td>
<td>1.50</td>
</tr>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		• comprehensive care plan established, implemented, revised, or monitored~~.~~; first 30 minutes, provided personally by a physician or other qualified health care professional, per calendar month. (Do not report 99491 in the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99439, 99487, 99489, 99490, 99605, 99606, 99607) ~~*(Do not report 99491 in conjunction with 99339, 99340)*~~		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

●99437	BB8	each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) (Use 99437 in conjunction with 99491) (Do not report 99437 for less than 30 minutes) (Do not report 99491, 99437 in the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99490, 99439, 99424, 99425, 99426, 99427) (Do not report 99491, 99437 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607)	ZZZ	1.00

Table for Reporting Chronic Care Management Services

Total Duration Care Management Services	**Staff Type**	**Chronic Care Management**
Less than 20 minutes	Not reported separately	Not reported separately
Less than 30 minutes	Physician/Other Qualified Health Care Professional	Not reported separately or see 99490
20 to 39 minutes	Clinical Staff	*99490 X 1*
30 to 59 minutes	Physician/Other Qualified Health Care Professional	*99491 X 1*
40 - 59 minutes	Clinical Staff	*99490 X 1 and 99439 X 1*
60 – 89 minutes ~~or more~~ *~~(1 hour or more)~~*	Physician/Other Qualified Health Care Professional	*99491 X 1 and 99437 X 1*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

90 minutes or more	Physician/Other Qualified Health Care Professional	99491 X 1 and 99437 X 2 and as appropriate based on illustrated examples above.
	~~Clinical Staff~~	~~99490 X 1 and 99439 X2~~
60 minutes or more (1 hour or more)	Clinical Staff	99490 X 1 and 99439 X 2

Complex Chronic Care Management Services

Complex chronic care management services are services that require at least 60 minutes clinical staff time, under the direction of a physician or other qualified healthcare professional. ~~provided during a calendar month that includes criteria for chronic care management services including establishing, revising, implementing, or monitoring the care plan; medical, functional, and/or psychosocial problems requiring medical decision making of moderate or high complexity; and clinical staff care management services for at least 60 minutes, under the direction of a physician or other qualified health care professional~~ Complex chronic care management services require moderate or high ~~M~~medical decision making as defined in the Evaluation and Management (E/M) guidelines. ~~is determined by the problems addressed by the reporting individual during the month.~~

Patients who require complex chronic care management services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, and/or repeat admissions or emergency department visits. Typical adult patients who receive complex chronic care management services are treated with three or more prescription medications and may be receiving other types of therapeutic interventions (eg, physical therapy, occupational therapy). Typical pediatric patients receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy). All patients have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Typical patients have complex diseases and morbidities and, as a result, demonstrate one or more of the following:

- *need for the coordination of a number of specialties and services;*
- *inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver;*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

• *psychiatric and other medical comorbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care; and/or* • *social support requirements or difficulty with access to care.*				
(f)99487	BB9	Complex chronic care management services, with the following required elements: • multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, • chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, • comprehensive care plan established, implemented, revised, or monitored, • moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)	XXX	1.81

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(f)✚99489	BB10	each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) (Report 99489 in conjunction with 99487) (Do not report 99489 for care management service~~s of~~ less than 30 minutes ~~additional to the first 60 minutes of complex chronic care management services during a calendar month~~) (Do not report 99487, 99489, during the same calendar month with 90951-90970, 99339, 99340, 99374, 99735, 99377, 99378, 99379, 99380, 99439, 94490, 99491, 99437, 99424, 99425, 99426, 99427~~,~~ ~~99605, 99606, 99607~~) (Do not report 99487, 99489 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607)	ZZZ	1.00
~~G2058~~	-	~~Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure). (do not report g2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month). (use g2058 in conjunction with 99490). (do not report 99490, g2058 in the same calendar month as 99487, 99489, 99491)).~~	~~ZZZ~~	N/A (CMS Deleted for 2021)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Principal Care Management Services

Principal care management represents services which focus on the medical and/or psychological needs manifested by a single complex chronic condition expected to last at least three months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease. Code 99424 is reported for at least 30 minutes of physician or other qualified health care professional personal time in care management activities during a calendar month. Code 99425 is reported in conjunction with 99424 when at least an additional 30 minutes of physician or other qualified health care professional personal time is spent in care management activities during the calendar month. Code 99426 is reported for the first 30 minutes of clinical staff time spent in care management activities during the calendar month. Code 99427 is reported in conjunction with 99426 when at least an additional 30 minutes of clinical staff time is spent in care management activities during the calendar month.

●99424	BB1	Principal care management services, for a single high-risk disease, with the following required elements: • one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, • the condition requires development, monitoring, or revision of disease-specific care plan, • the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities • ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month	XXX	1.45

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

+●99425	BB2	additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) (Use 99425 in conjunction with 99424) (Principal care management services of less than 30 minutes duration in a calendar month are not reported separately) (Do not report 99424, 99425 in the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607, 99437, 99426, 99427) (Do not report 99424, 99425 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607)	ZZZ	1.00
●99426	BB3	Principal care management services, for a single high-risk disease, with the following required elements; • one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, • the condition requires development, monitoring, or revision of disease-specific care plan, • the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities, • ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.	XXX	1.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

✚●99427	BB4	each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) (Use 99427 in conjunction with 99426) (Principal care management services of less than 30 minutes duration, in a calendar month, are not reported separately) (Do not report 99427 more than twice per calendar month) (Do not report 99426, 99427 in the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99439, 99487, 99489, 99490, 99491, 99437, 99424, 99425, 99605, 99606, 99607,) (Do not report 99426, 99427 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607)	ZZZ	0.71
~~G2064~~	-	~~Comprehensive care management services for a single high risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities~~	~~XXX~~	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

~~G2065~~	-	~~Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities~~	~~XXX~~	N/A

Table for Reporting Complex Chronic Care Management Services

Total Duration Principal Care Management Services	**Staff Type**	**Principal Care Management**
Less than 30 minutes	Not reported separately	Not reported separately
30 to 59 minutes	Physician/Other Qualified Health Care Professional	99424 X 1
	Clinical Staff	99426 X 1
60 to 89 minutes ~~or more~~	Physician/Other Qualified Health Care Professional	99424 X 1 and 99425 X1

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

~~(1 hour or more)~~	Clinical Staff	99426 X 1 and 99427 X 1
90 to 119 minutes	Physician/Other Qualified Health Care Professional	99426 X 1 and 99425 X 2
	Clinical Staff	99426 X 1 and 99427 X 2
120 minutes or more	Physician/Other Qualified Health Care Professional	99424 X 1 and 99425 X 3, and as appropriate based on illustrated examples above.
	Clinical Staff	99426 X 1 and 99427 X 2

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Table A

CARE MANAGEMENT SERVICES				
CODE	**SERVICE**	**STAFF TYPE**	**Unit duration (time span ~~max~~)**	**UNIT MAX PER MONTH**
99490	Chronic Care Management	Clinical Staff	20 min (20-39)	1
+99439	Chronic Care Management	Clinical Staff	40-59 min x 1, (60 or more min x 2)	2
99491	Chronic Care Management	Physician/Other Qualified Health Care Professional	30 min (30-59)	1
+99437	Chronic Care Management	Physician/Other Qualified Health Care Professional	30 min (60 or more)	No Limit
99487	Complex Chronic Care Management	Clinical Staff	60 min (60-89)	1
+99489	Complex Chronic Care Management	Clinical Staff	30 min (≥90 x 1) (≥ 120 x 2) etc	No limit

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

99424	Principal Care Management	Physician/Other Qualified Health Care Professional	30 min (30-59)	1
+99425	Principal Care Management	Physician/Other Qualified Health Care Professional	30 min (60 or more)	No Limit
99426	Principal Care Management	Clinical Staff	30 min (30-59)	1
+99427	Principal Care Management	Clinical Staff	30 min (60 or more)	2

General Behavioral Health Integration Care Management

#99484 *Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:*

- *initial assessment or follow-up monitoring, including the use of applicable validated rating scales;*
- *behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;*
- *facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and*
- *continuity of care with a designated member of the care team.*

(Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month)

(E/M services, including care management services [99439, 99487, 99489, 99490, 99491, 99495, 99496, 99437, 99424, 99425, 99426, 99427], and psychiatric services [90785-90899] may be reported separately by the same physician or other qualified health care professional on the same day or during the same calendar month, but time and activities used to meet criteria for another reported service do not count toward meeting criteria for 99484)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Medicine

Dialysis

End-Stage Renal Disease Services

Codes 90951-90962 are reported **...**

...

Report inpatient E/M services as appropriate. Dialysis procedures rendered during the hospitalization (July 11-27) should be reported as appropriate (90935-90937, 90945-90947).

(Do not report 90951-90970 during the same month in conjunction with 99439, 99487, 99489, 99490, 99491, 99437, 99424, 99425, 99426, 99427)

Non-Face-to-Face Nonphysician Services

Telephone Services

Telephone services are non-face-to-face . . .

(For telephone services provided by a physician, see 99441-99443)

98966 *Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment;5-10 minutes of medical discussion*

98967 *11-20 minutes of medical discussion*

98968 *21-30 minutes of medical discussion*

(Do not report 98966-98968 during the same month with 99439, 99487, 99489, 99490, 99491, 99426, 99427)

(Do not report 98966, 98967, 98968 in conjunction with 93792, 93793)

Qualified Nonphysician Health Care Professional Online Digital Evaluation and Management Service

98970 *Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes*

98971 *11-20 minutes*

98972 *21 or more minutes*

(Report 98970, 98971, 98972 once per 7-day period)

(Do not report online digital E/M services for cumulative visit time less than 5 minutes)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(Do not count 98970, 98971, 98972 time otherwise reported with other services)

(Do not report 98970, 98971, 98972 for home and outpatient INR monitoring when reporting 93792, 93793)

(Do not report 98970, 98971, 98972 when using 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99490, 99491, 99437, 99426, 99427 for the same communication[s])

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99490 Tracking Number Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: XXX Current Work RVU: **0.61** RUC Recommended RVU: **1.00**

CPT Descriptor: Chronic care management services, with the following required elements:

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

first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: (Adult) A 75-year-old female with diabetes, hypertension, and mild congestive heart failure. She requires chronic care management services.

(Child) A 3-year-old former 26-week preterm child presents with bronchopulmonary dysplasia, chronic lung disease, status post tracheostomy, and cerebral palsy. Patient receives physical, occupational and speech therapy services and requires chronic care management services.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Chronic care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient with two or more chronic diseases residing at home or in a domiciliary, rest home, assisted living facility, or nursing home. This service typically involves at least 20 minutes of clinical staff time implementing a care plan directed by the physician or other qualified health care professional, per calendar month, when medical and/or psychosocial needs of the patient require establishing and implementing, revising, or monitoring the care plan. Services typically include establishing, implementing, revising, or monitoring the care plan; coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.

A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community and social services ordered, how the services of agencies and specialists unconnected to the practice will be directed and coordinated,

identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.

The care management office/practice must have the following capabilities:
Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients and caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week; provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; provide timely access and management for follow up after an emergency department visit or facility discharge; utilize an electronic health record system so that care providers have timely access to clinical information; use a standardized methodology to identify patients who require care management services; have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner; use a form and format in the medical record that is standardized within the practice; be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA					
Specialty Society(ies):	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA					
CPT Code:	99490					
Sample Size:	28190	**Resp N:**	84			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**12.00**	50.00	800.00	
Survey RVW:	0.40	1.00	**1.20**	1.52	60.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	1.00	20.00	**25.00**	30.00	60.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99490	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0181	XXX	1.73	**RUC Time**

CPT Descriptor Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99497	XXX	1.50	**RUC Time**

CPT Descriptor Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99231	XXX	0.76	**RUC Time**	6,736,945

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99308	XXX	1.16	**RUC Time**	11,302,104

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 11.9 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 10.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99490	Top Key Reference CPT Code: G0181	2nd Key Reference CPT Code: **99497**
Median Pre-Service Time	0.00	10.00	5.00
Median Intra-Service Time	25.00	32.00	30.00
Median Immediate Post-service Time	0.00	15.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**25.00**	**57.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	6%	50%	10%	34%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	45%	50%
Physical effort required	25%	70%	5%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	10%	60%	30%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	60%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	10%	80%	10%
Physical effort required	0%	60%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	80%	20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Compelling Evidence

The panel considered whether there was compelling evidence for an increase in work RVUs for the CCM codes. The panel reviewed a number of articles on how medical care is shifting from the office to the home.

As evidenced by the included literature:

CCM has significantly increased in complexity because complex medical conditions can now more often be managed while the patient is at home instead of during face-to-face services. For example, services to patients with heart failure, diabetes, and autoimmune disorders can be provided by, or under the supervision of, QHP while the patient is at home in order to decrease emergency department visits, hospitalizations, and placement in nursing homes and to improve quality of life. This shift occurred before COVID-19, was accelerated by COVID-19, and will continue after COVID-19.

The shift to caring for sicker, more complex patients began a little more than ten years ago, shortly before the CCM codes were established. The rapid evolution of sophisticated tools such as remote monitoring apps, self-management apps, ability for patients to transmit complex data (e.g., high resolution photographs) in real time has increased the ability to care for patients remotely. Development of robust remote monitoring technologies (e.g., measurement of pulmonary artery pressures via permanently

implanted sensors, continuous monitoring of vital signs by sensors that are able to transmit data over the internet in real-time) also enables clinicians to make diagnoses and alter treatment regimens without needing to see a patient face-to-face.

Clinicians can now often stratify patients according to risk remotely so that they have time to properly care for those patients who require office visits. This can mean that some patients are now contacted daily instead of weekly. The need to recognize and treat mental health issues has also increased as more and more evidence demonstrates that psychosocial issues play a major role in the treatment of chronic disease and contact with family members and caregivers is essential to help keep these patients functional and able to live at home.

The COVID-19 pandemic has accelerated this transformation and increased the number and complexity of patients needing CCM in order to keep them out of the hospital and to identify those patients who are deteriorating and need admission. COVID-19 has also highlighted the need for physicians to continually counsel patients on lifestyle choices that go far beyond the usual advice regarding exercise and diet. While the need to counsel on socially distancing and wearing a mask may be temporary, the heightened awareness of how all our patients' choices can influence disease management is a permanent addition to the matters in which QHPs and their clinical staff interact with patients.

In summary, the complexity of CCM has significantly increased since the codes were established.

Specifically, the CCM codes meet the following RUC criterion for compelling evidence:

> Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
> ▪ technique
> ▪ **knowledge/technology**
> ▪ **patient populations**
> ▪ site-of-service
> ▪ length of hospital stay
> ▪ physician time

Literature:

1.) Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients, Bruce Leff 1, Lynda Burton, Scott L Mader, Bruce Naughton, Jeffrey Burl, Sharon K Inouye, William B Greenough 3rd, Susan Guido, Christopher Langston, Kevin D Frick, Donald Steinwachs, John R Burton Affiliations expand

- PMID: 16330791
- DOI: 10.7326/0003-4819-143-11-200512060-00008

Background: Acutely ill older persons often experience adverse events when cared for in the acute care hospital.
Objective: To assess the clinical feasibility and efficacy of providing acute hospital-level care in a patient's home in a hospital at home.
Participants: 455 community-dwelling elderly patients who required admission to an acute care hospital for community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis.
Intervention: Treatment in a hospital-at-home model of care that substitutes for treatment in an acute care hospital.
Measurements: Clinical process measures, standards of care, clinical complications, satisfaction with care, functional status, and costs of care.
Results: Hospital-at-home care was feasible and efficacious in delivering hospital-level care to patients at home. In 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care; in the third site, 29% of patients chose hospital-at-home care. Although less procedurally oriented than acute hospital care, hospital-at-home care met quality standards at rates similar to those of acute hospital care. On an intention-to-treat basis, patients treated in hospital-at-home had a shorter length of stay (3.2 vs. 4.9 days) ($P = 0.004$), and there was some evidence that they also had fewer complications. The mean cost was lower for hospital-at-home care than for acute hospital care (5081 dollars vs. 7480 dollars) ($P < 0.001$).
Conclusions: The hospital-at-home care model is feasible, safe, and efficacious for certain older patients with selected acute medical illnesses who require acute hospital-level care. Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition t

2.) Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients. Am J Manag Care. 2020 Feb 1;26(2):e57-e63. doi: 10.37765/ajmc.2020.42402.

https://pubmed.ncbi.nlm.nih.gov/32059101/

3.) The Common Attributes of Successful Care Manager Programs for High-Need, High-Cost Persons: A Cross-Case Analysis. Ambul Care Manage. 2019 Oct/Dec;42(4):230-241. doi:0.1097/JAC.0000000000000305.PMID: 31449160

https://pubmed.ncbi.nlm.nih.gov/31449160/

4.) Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals. November 10, 2015. The American Journal of Managed Care, November 2015, Volume 21, Issue 11

https://pubmed.ncbi.nlm.nih.gov/26735292/" https://pubmed.ncbi.nlm.nih.gov/26735292/

Summary: Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition to outside of traditional face-to-face office visits.

Therefore, the panel believes that compelling evidence has been met.

Discussion 99490

The panel reviewed the CCM codes first and started with 99490, chronic care management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

There were 84 responses and 88% of respondents found the vignettes to be typical. The current values for 99490 are 15 minutes (all intra) and a work RVU of 0.61. The panel noted that the current time and work are far below the 25th percentile of the previous survey which were 20 minutes and a work RVU of 1.00. Note that the median time and work from the previous survey were 30 and 1.50.

The current survey had a median time of 25 minutes and a median work RVU of 1.30 and a time of 20 minutes and work RVU of 1.00 at the 25th percentile. The two most common reference services were G0181, *Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30* minutes or more, which has times of 10/32/15/57 and a work RVU of 1.73 and 99497, *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate,* which has times and a work RVU of 5/30/10/45/1.50.

Given that the office visit codes were not on the RSL, the panel agreed that these were appropriate reference services. In fact, the panel agreed that the median time (25 minutes) and 25th percentile work RVU (1.00) fit in correct rank order to both reference services. For example, 99497 has a higher total time of 45 minutes and an intra time of 30 minutes with a RVU of 1.5. The median survey time of 25 minutes is 55% of the total time of 99497 and the median intraservice time of 25 minutes is 83% that of 99497 while the 25th percentile survey RVU of 1.0 is 66% that of 99497.

In addition, the survey median of 25 minutes and 25th percentile RVU of 1.0 results in an IWPUT (0.040) which is virtually identical to the current IWPUT (0.041).

In summary, the surveys from both 2014 and 2020 supported a higher time than 15 minutes and a higher RVU than 0.61 and the panel agreed that the values from the current survey were appropriate.

Therefore, the societies recommend the median time of 25 minutes and 25th percentile work RVU of 1.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99490

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See associated frequency spreadsheet) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 12564684
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumed to be three times Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,188,228 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims volume from RUC database

Specialty (See associated frequency spreadsheet) Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99490

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99439 Tracking Number Original Specialty Recommended RVU: **0.70**
Presented Recommended RVU: **0.70**
Global Period: ZZZ Current Work RVU: **0.54** RUC Recommended RVU: **0.70**

CPT Descriptor: Chronic care management services, with the following required elements:

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

each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a month of chronic care management services, a 78-year-old female or 3 year old who has just received 39 minutes of clinical staff time, requires additional care management services.

[Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 99490.]

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Chronic care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient with two or more chronic diseases residing at home or in a domiciliary, rest home, assisted living facility, or nursing home. This service typically involves 20 additional minutes of clinical staff implementing a care plan directed by the physician or other qualified health care professional when medical and/or psychosocial needs of the patient require establishing and implementing, revising, or monitoring the care plan. Services typically include establishing, implementing, revising, or monitoring the care plan; coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.

A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community and social services ordered, how the services of agencies and specialists unconnected to the practice will be directed and coordinated,

identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.

The care management office/practice must have the following capabilities:
Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients and caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week; provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; provide timely access and management for follow up after an emergency department visit or facility discharge; utilize an electronic health record system so that care providers have timely access to clinical information; use a standardized methodology to identify patients who require care management services; have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner; use a form and format in the medical record that is standardized within the practice; be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA					
Specialty Society(ies):	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA					
CPT Code:	99439					
Sample Size:	28190	**Resp N:**	75			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**5.00**	20.00	500.00	
Survey RVW:	0.20	0.70	**0.93**	1.10	20.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	20.00	**20.00**	30.00	70.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	99439	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99231	XXX	0.76	**RUC Time**

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99457	XXX	0.61	**RUC Time**

CPT Descriptor Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99407	XXX	0.50	**RUC Time**	83,194

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99231	XXX	0.76	**RUC Time**	6,736,945

CPT Descriptor 2 ubsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's

Other Reference CPT Code	Global	Work RVU	Time Source

99238 XXX 1.28 **RUC Time**

CPT Descriptor Hospital discharge day management; 30 minutes or less

---

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 12.0 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 10.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99439	Top Key Reference CPT Code: 99231	2nd Key Reference CPT Code: **99457**
Median Pre-Service Time	0.00	5.00	0.00
Median Intra-Service Time	20.00	10.00	20.00
Median Immediate Post-service Time	0.00	5.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**20.00**	**20.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	20%	25%	20%	35%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	60%	20%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	60%	20%
Physical effort required	33%	33%	34%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	40%	60%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	10%	25%	35%	30%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	25%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	50%	45%
Physical effort required	25%	40%	35%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	55%	20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Compelling Evidence

The panel considered whether there was compelling evidence for an increase in work RVUs for the CCM codes. The panel reviewed a number of articles on how medical care is shifting from the office to the home.

As evidenced by the included literature:

CCM has significantly increased in complexity because complex medical conditions can now more often be managed while the patient is at home instead of during face-to-face services. For example, services to patients with heart failure, diabetes, and autoimmune disorders can be provided by, or under the supervision of, QHP while the patient is at home in order to decrease emergency department visits, hospitalizations, and placement in nursing homes and to improve quality of life. This shift occurred before COVID-19, was accelerated by COVID-19, and will continue after COVID-19.

The shift to caring for sicker, more complex patients began a little more than ten years ago, shortly before the CCM codes were established. The rapid evolution of sophisticated tools such as remote monitoring apps, self-management apps, ability for patients to transmit complex data (e.g., high resolution photographs) in real time has increased the ability to care for patients remotely. Development of robust remote monitoring technologies (e.g., measurement of pulmonary artery pressures via permanently implanted sensors, continuous monitoring of vital signs by sensors that are able to transmit data over the internet in real-time) also enables clinicians to make diagnoses and alter treatment regimens without needing to see a patient face-to-face.

Clinicians can now often stratify patients according to risk remotely so that they have time to properly care for those patients who require office visits. This can mean that some patients are now contacted daily instead of weekly. The need to recognize and treat mental health issues has also increased as more and more evidence demonstrates that psychosocial issues play a major role in the treatment of chronic disease and contact with family members and caregivers is essential to help keep these patients functional and able to live at home.

The COVID-19 pandemic has accelerated this transformation and increased the number and complexity of patients needing CCM in order to keep them out of the hospital and to identify those patients who are deteriorating and need admission. COVID-19 has also highlighted the need for physicians to continually counsel patients on lifestyle choices that go far beyond the usual advice regarding exercise and diet. While the need to counsel on socially distancing and wearing a mask may be temporary, the heightened awareness of how all our patients' choices can influence disease management is a permanent addition to the matters in which QHPs and their clinical staff interact with patients.

In summary, the complexity of CCM has significantly increased since the codes were established.

Specifically, the CCM codes meet the following RUC criterion for compelling evidence:

> Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
> ▪ technique
> ▪ **knowledge/technology**
> ▪ **patient populations**
> ▪ site-of-service
> ▪ length of hospital stay
> ▪ physician time

Literature:

1.) Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients, Bruce Leff 1, Lynda Burton, Scott L Mader, Bruce Naughton, Jeffrey Burl, Sharon K Inouye, William B Greenough 3rd, Susan Guido, Christopher Langston, Kevin D Frick, Donald Steinwachs, John R Burton Affiliations expand

- PMID: 16330791
- DOI: 10.7326/0003-4819-143-11-200512060-00008

Background: Acutely ill older persons often experience adverse events when cared for in the acute care hospital.
Objective: To assess the clinical feasibility and efficacy of providing acute hospital-level care in a patient's home in a hospital at home.
Participants: 455 community-dwelling elderly patients who required admission to an acute care hospital for community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis.
Intervention: Treatment in a hospital-at-home model of care that substitutes for treatment in an acute care hospital.
Measurements: Clinical process measures, standards of care, clinical complications, satisfaction with care, functional status, and costs of care.
Results: Hospital-at-home care was feasible and efficacious in delivering hospital-level care to patients at home. In 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care; in the third site, 29% of patients chose hospital-at-home care. Although less procedurally oriented than acute hospital care, hospital-at-home care met quality standards at rates similar to those of acute hospital care. On an intention-to-treat basis, patients treated in hospital-at-home had a shorter length of stay (3.2 vs. 4.9 days) ($P = 0.004$), and there was some evidence that they also had fewer complications. The mean cost was lower for hospital-at-home care than for acute hospital care (5081 dollars vs. 7480 dollars) ($P < 0.001$).
Conclusions: The hospital-at-home care model is feasible, safe, and efficacious for certain older patients with selected acute medical illnesses who require acute hospital-level care. Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition t

2.) Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients. Am J Manag Care. 2020 Feb 1;26(2):e57-e63. doi: 10.37765/ajmc.2020.42402.

https://pubmed.ncbi.nlm.nih.gov/32059101/

3.) The Common Attributes of Successful Care Manager Programs for High-Need, High-Cost Persons: A Cross-Case Analysis. Ambul Care Manage. 2019 Oct/Dec;42(4):230-241. doi:0.1097/JAC.0000000000000305.PMID: 31449160

https://pubmed.ncbi.nlm.nih.gov/31449160/

4.) Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals. November 10, 2015. The American Journal of Managed Care, November 2015, Volume 21, Issue 11

https://pubmed.ncbi.nlm.nih.gov/26735292/" https://pubmed.ncbi.nlm.nih.gov/26735292/

Summary: Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition to outside of traditional face-to-face office visits.

Therefore, the panel believes that compelling evidence has been met.

Discussion 99439

The panel reviewed 99439 which is the add-on code to 99490 and which will replace G2058 in 2021. Both have identical descriptors: *Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure). (do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month)*.

CMS created G2058 and its current values are based on a Centers for Medicare and Medicaid Services (CMS) crosswalk from 99490 (work RVU of 0.61 and time of 15 minutes). In January 2020, the RUC reviewed 99439 which was established at the September 2019 CPT meeting. The RUC had agreed that a survey of 99439 should be delayed until 2020 so the entire family of CCM and PCM services could be surveyed at once. After its review, the RUC recommended a work RVU of 0.54 and time of 15 minutes, based on a crosswalk from 11107 Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure) and 96171 *Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)*. This will be the value for G2058 for 2001 until it is replaced by 99439 in 2021.

The survey for 99439 had 75 respondents, of whom 91% agreed that vignette was typical. The survey had a median work RVU of 0.93 and a median intra/total time of 20 minutes. The survey 25th percentile RVU was 0.70. The main reference services were 99457, *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes*, with a work RVU of 0.61 and total/intra time of 20 minutes, 99238, *Hospital discharge day management, 30 minutes or less* with a work RVU of 1.28 and times of 8/20/10/38, and 99231, *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit*, with times 5/10/5/20 and a and work RVU of 0.76.

The expert panel agreed that the work RVU for 99439 should be less than the work RVU for 99490 and that the 25th percentile work RVU placed this add-on code in correct rank order with 99490 because the median time was 20 minutes (20% less than for 99490). In addition, the median survey time for 99439 was identical to the time for 99457, the first key reference service, and the survey 25th percentile work RVU of 0.70 is slightly higher than that of 99457 and reflects the higher intensity of 99439 because the patient population is sicker than that of 99497. Similarly, these values place 99439 in correct rank order to 99231 which is a hospital inpatient service with similar total time and a higher work RVU. In addition, the resultant IWPUT of 0.035 is appropriate and places it in proper rank order with 99490 (0.040).

Therefore, the specialties recommend a time of 20 minutes and a work RVU of 0.63 for 99439.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

3.	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
4.	99490	XXX	1.00	0	25	0
5.	+99439	ZZZ	0.61	0	20	0
6.	Total		1.61	0	45	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99490

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See associated frequency spreadsheet) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10051747
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumed to be three times estimated Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,350,582 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated Medicare utilization assumed to be 80% of 99490, based on 99489 as percent of 99487

Specialty (See associated frequency spreadsheet) Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99490

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99491 Tracking Number Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: XXX Current Work RVU: **1.45** RUC Recommended RVU: **1.50**

CPT Descriptor: Chronic care management services with the following required elements:

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

first 30 minutes, provided personally by a physician or other qualified health care professional, per calendar month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
(Adult) An 83-year-old female with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program, and sees a cardiologist and neurologist.

(Child) A 6-year-old boy with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airway disease, chronic seizure disorder, failure to thrive, and severe neurodevelopment delay. He receives home occupational, physical, and speech therapy services.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: A physician or other qualified health care professional personally provides at least 30 minutes of chronic care management (CCM) services, per calendar month, to a patient with two or more chronic conditions residing at home or in a domiciliary, rest home, assisted living facility, or nursing home. These services typically include establishing, implementing, revising, or monitoring the care plan; coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides and/or oversees the coordination of services as needed for all medical conditions, psychosocial needs, and activities of daily living and documents and shares a plan of care with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements:

- Problem list;
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;

- Planned interventions;
- Medication management;
- Community and social services ordered;
- How the services of agencies and specialists not associated with the practice will be directed and coordinated;
- Identification of the individuals responsible for each intervention;
- Requirements for periodic review; and
- When applicable, revision of the care plan.

In addition, the care management office/practice must have the following capabilities:

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff, including providing patients and caregivers with a means to make contact with health care professionals in the practice to address urgent needs, regardless of the time of day or day of week;
- Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Provide timely access and management for follow up after an emergency department visit or facility discharge;
- Use an electronic health record system so that care providers have timely access to clinical information; and
- Engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA					
Specialty Society(ies):	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA					
CPT Code:	99491					
Sample Size:	28190	**Resp N:**	55			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**5.00**	23.00	500.00	
Survey RVW:	0.50	1.50	**1.75**	2.00	75.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	14.00	30.00	**33.00**	41.00	145.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99491	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**33.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0181	XXX	1.73	**CMS Time File**

CPT Descriptor Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99239	XXX	1.90	**RUC Time**

CPT Descriptor Hospital discharge day management; more than 30 minutes

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99232	XXX	1.39	**RUC Time**	44,656,174

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99309	XXX	1.55	**RUC Time**	10,009,767

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care

professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 **% of respondents:** 25.4 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 12.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99491	**Top Key Reference CPT Code:** G0181	**2nd Key Reference CPT Code:** **99239**
Median Pre-Service Time	0.00	10.00	10.00
Median Intra-Service Time	33.00	32.00	30.00
Median Immediate Post-service Time	0.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**33.00**	**57.00**	**55.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	12%	30%	20%	38%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	40%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	65%	35%
Physical effort required	10%	80%	10%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	45%	50%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	40%	60%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	45%	35%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	80%	20%
Physical effort required	20%	25%	55%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	30%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Compelling Evidence

The panel considered whether there was compelling evidence for an increase in work RVUs for the CCM codes. The panel reviewed a number of articles on how medical care is shifting from the office to the home.

As evidenced by the included literature:

CCM has significantly increased in complexity because complex medical conditions can now more often be managed while the patient is at home instead of during face-to-face services. For example, services to patients with heart failure, diabetes, and autoimmune disorders can be provided by, or under the supervision of, QHP while the patient is at home in order to decrease emergency department visits, hospitalizations, and placement in nursing homes and to improve quality of life. This shift occurred before COVID-19, was accelerated by COVID-19, and will continue after COVID-19.

The shift to caring for sicker, more complex patients began a little more than ten years ago, shortly before the CCM codes were established. The rapid evolution of sophisticated tools such as remote monitoring apps, self-management apps, ability for patients to transmit complex data (e.g., high resolution photographs) in real time has increased the ability to care for patients remotely. Development of robust remote monitoring technologies (e.g., measurement of pulmonary artery pressures via permanently

implanted sensors, continuous monitoring of vital signs by sensors that are able to transmit data over the internet in real-time) also enables clinicians to make diagnoses and alter treatment regimens without needing to see a patient face-to-face.

Clinicians can now often stratify patients according to risk remotely so that they have time to properly care for those patients who require office visits. This can mean that some patients are now contacted daily instead of weekly. The need to recognize and treat mental health issues has also increased as more and more evidence demonstrates that psychosocial issues play a major role in the treatment of chronic disease and contact with family members and caregivers is essential to help keep these patients functional and able to live at home.

The COVID-19 pandemic has accelerated this transformation and increased the number and complexity of patients needing CCM in order to keep them out of the hospital and to identify those patients who are deteriorating and need admission. COVID-19 has also highlighted the need for physicians to continually counsel patients on lifestyle choices that go far beyond the usual advice regarding exercise and diet. While the need to counsel on socially distancing and wearing a mask may be temporary, the heightened awareness of how all our patients' choices can influence disease management is a permanent addition to the matters in which QHPs and their clinical staff interact with patients.

In summary, the complexity of CCM has significantly increased since the codes were established.

Specifically, the CCM codes meet the following RUC criterion for compelling evidence:

> Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
> ▪ technique
> ▪ **knowledge/technology**
> ▪ **patient populations**
> ▪ site-of-service
> ▪ length of hospital stay
> ▪ physician time

Literature:

1.) Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients, Bruce Leff 1, Lynda Burton, Scott L Mader, Bruce Naughton, Jeffrey Burl, Sharon K Inouye, William B Greenough 3rd, Susan Guido, Christopher Langston, Kevin D Frick, Donald Steinwachs, John R Burton Affiliations expand

- PMID: 16330791
- DOI: 10.7326/0003-4819-143-11-200512060-00008

Background: Acutely ill older persons often experience adverse events when cared for in the acute care hospital.
Objective: To assess the clinical feasibility and efficacy of providing acute hospital-level care in a patient's home in a hospital at home.
Participants: 455 community-dwelling elderly patients who required admission to an acute care hospital for community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis.
Intervention: Treatment in a hospital-at-home model of care that substitutes for treatment in an acute care hospital.
Measurements: Clinical process measures, standards of care, clinical complications, satisfaction with care, functional status, and costs of care.
Results: Hospital-at-home care was feasible and efficacious in delivering hospital-level care to patients at home. In 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care; in the third site, 29% of patients chose hospital-at-home care. Although less procedurally oriented than acute hospital care, hospital-at-home care met quality standards at rates similar to those of acute hospital care. On an intention-to-treat basis, patients treated in hospital-at-home had a shorter length of stay (3.2 vs. 4.9 days) ($P = 0.004$), and there was some evidence that they also had fewer complications. The mean cost was lower for hospital-at-home care than for acute hospital care (5081 dollars vs. 7480 dollars) ($P < 0.001$).
Conclusions: The hospital-at-home care model is feasible, safe, and efficacious for certain older patients with selected acute medical illnesses who require acute hospital-level care. Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition t

2.) Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients. Am J Manag Care. 2020 Feb 1;26(2):e57-e63. doi: 10.37765/ajmc.2020.42402.

https://pubmed.ncbi.nlm.nih.gov/32059101/

3.) The Common Attributes of Successful Care Manager Programs for High-Need, High-Cost Persons: A Cross-Case Analysis. Ambul Care Manage. 2019 Oct/Dec;42(4):230-241. doi:0.1097/JAC.0000000000000305.PMID: 31449160

https://pubmed.ncbi.nlm.nih.gov/31449160/

4.) Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals. November 10, 2015. The American Journal of Managed Care, November 2015, Volume 21, Issue 11

https://pubmed.ncbi.nlm.nih.gov/26735292/" https://pubmed.ncbi.nlm.nih.gov/26735292/

Summary: Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition to outside of traditional face-to-face office visits.

Therefore, the panel believes that compelling evidence has been met.

Discussion 99491
The panel reviewed the QHP CCM code 99491, *Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.*

The survey had 55 respondents, 87% of whom found the vignette to be typical.
The current times 0/30/0/30 and work RVU are 1.45 which were the median and 25th percentile figures respectively, from the previous survey in 2017. The current survey median time was 33 minutes, the median work RVU was 1.75, and the 25th percentile RVU was 1.50. The two key reference services were G0181 with times 10/32/15/57 and work RVU of 1.73 and 99239, *Hospital discharge day management, greater than 30 minutes*, with times 10/30/15/55 and work RVU of 1.90. The expert panel agreed that the median time of 33 minutes was appropriate and the 25th percentile work RVU of 1.50 was also appropriate and placed 99491 in correct rank order with the key reference services and with 99490 and 99487.

The survey intra time for 99491 was one minute higher than both key reference services but lower than total time by 24 and 22 minutes, respectively. The panel also noted that this code is reported for the first 30 minutes of QHP time, but that it was not surprising that QHPs were spending more than 30 minutes in providing this service. Therefore, the 25th percentile survey work RVU places 99491 in correct rank order with both key reference services.

The panel then considered whether these values placed 99491 in proper rank order with 99490 and 99487. The panel agreed that they did. For example, the survey QHP time of 45 minutes for 99487 which is reported based on a minimum of 60 minutes of clinical staff time was appropriately longer than the survey QHP time of 33 minutes for a code that is reported based on QHP time - not staff time. Further, a work RVU for 99491 of 1.50 places 99491 in proper rank order to a work value of 1.81 for 99487. Specifically, the recommended QHP time of 33 minutes is 73% of the recommended QHP time for 99487 and the recommended work RVU for 99491 is 83% of the recommended work RVU for 99487. Similarly, the recommended QHP time of 33 minutes for 99491 is 32% higher than the recommended QHP time for 99490 and the recommended work RVU of 1.5 is 50% higher than the recommended work RVU for 99490.

Therefore, the expert panel recommends the survey median of 33 minutes and the 25th percentile work RVU of 1.50.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99491

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See associated frequency spreadsheet) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 144273
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumed to be three times estimated Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 48,091 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99491

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99437 Tracking Number Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **1.00**

CPT Descriptor: Chronic care management services with the following required elements:

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

each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
(Adult) An 80-year-old male who has already received 59 minutes of physician or qualified healthcare professional chronic care management services during the calendar month requires additional care management services during the same calendar month.

[Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code [99491].]

(Child) An 11-year-old female with past medical history of meconium aspiration at birth resulting in anoxic brain injury with cerebral palsy, asthma, allergic rhinitis and global developmental delay who has already received 59 minutes of physician or qualified healthcare professional chronic care management services during the calendar moth and requires additional care management services during the same calendar month.

[Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code [99491].]

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: A physician or other qualified health care professional personally provides these chronic care management (CCM) services, which are management and support services, to a patient with two or more chronic conditions residing at home or in a domiciliary, rest home, assisted living facility, or nursing home. These services typically include establishing, implementing, revising, or monitoring the care plan; coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides and/or oversees the coordination of services as needed for all medical conditions, psychosocial needs, and activities of daily living and documents and shares a plan of care with

the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements:

- Problem list;
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;
- Planned interventions;
- Medication management;
- Community and social services ordered;
- How the services of agencies and specialists not associated with the practice will be directed and coordinated;
- Identification of the individuals responsible for each intervention;
- Requirements for periodic review; and
- When applicable, revision of the care plan.

In addition, the care management office/practice must have the following capabilities:

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff, including providing patients and caregivers with a means to make contact with health care professionals in the practice to address urgent needs, regardless of the time of day or day of week;
- Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Provide timely access and management for follow up after an emergency department visit or facility discharge;
- Use an electronic health record system so that care providers have timely access to clinical information; and
- Engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA					
Specialty Society(ies):	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA					
CPT Code:	99437					
Sample Size:	28190	**Resp N:**	48			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**1.00**	15.00	100.00	
Survey RVW:	0.40	1.00	**1.29**	1.73	20.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	10.00	20.00	**30.00**	35.00	5280.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	99437	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0181	XXX	1.73	**CMS Time File**

CPT Descriptor Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99498	ZZZ	1.40	**RUC Time**

CPT Descriptor Advanced Care Planning, each additional 30 minutes

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99231	XXX	0.76	**RUC Time**	6,736,945

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99308	XXX	1.16	**RUC Time**	11,302,104

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians,

other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 20.8 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 10.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 99437	**Top Key Reference CPT Code:** G0181	**2nd Key Reference CPT Code:** **99498**
Median Pre-Service Time	0.00	10.00	0.00
Median Intra-Service Time	30.00	32.00	30.00
Median Immediate Post-service Time	0.00	15.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**57.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	20%	20%	30%	30%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	45%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	52%	30%
Physical effort required	35%	65%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	33%	50%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	20%	20%	60%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	40%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	45%	50%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	70%	30%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Compelling Evidence

The panel considered whether there was compelling evidence for an increase in work RVUs for the CCM codes. The panel reviewed a number of articles on how medical care is shifting from the office to the home.

As evidenced by the included literature:

CCM has significantly increased in complexity because complex medical conditions can now more often be managed while the patient is at home instead of during face-to-face services. For example, services to patients with heart failure, diabetes, and autoimmune disorders can be provided by, or under the supervision of, QHP while the patient is at home in order to decrease emergency department visits, hospitalizations, and placement in nursing homes and to improve quality of life. This shift occurred before COVID-19, was accelerated by COVID-19, and will continue after COVID-19.

The shift to caring for sicker, more complex patients began a little more than ten years ago, shortly before the CCM codes were established. The rapid evolution of sophisticated tools such as remote monitoring apps, self-management apps, ability for patients to transmit complex data (e.g., high resolution photographs) in real time has increased the ability to care for patients remotely. Development of robust remote monitoring technologies (e.g., measurement of pulmonary artery pressures via permanently

implanted sensors, continuous monitoring of vital signs by sensors that are able to transmit data over the internet in real-time) also enables clinicians to make diagnoses and alter treatment regimens without needing to see a patient face-to-face.

Clinicians can now often stratify patients according to risk remotely so that they have time to properly care for those patients who require office visits. This can mean that some patients are now contacted daily instead of weekly. The need to recognize and treat mental health issues has also increased as more and more evidence demonstrates that psychosocial issues play a major role in the treatment of chronic disease and contact with family members and caregivers is essential to help keep these patients functional and able to live at home.

The COVID-19 pandemic has accelerated this transformation and increased the number and complexity of patients needing CCM in order to keep them out of the hospital and to identify those patients who are deteriorating and need admission. COVID-19 has also highlighted the need for physicians to continually counsel patients on lifestyle choices that go far beyond the usual advice regarding exercise and diet. While the need to counsel on socially distancing and wearing a mask may be temporary, the heightened awareness of how all our patients' choices can influence disease management is a permanent addition to the matters in which QHPs and their clinical staff interact with patients.

In summary, the complexity of CCM has significantly increased since the codes were established.

Specifically, the CCM codes meet the following RUC criterion for compelling evidence:

> Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
> ▪ technique
> ▪ **knowledge/technology**
> ▪ **patient populations**
> ▪ site-of-service
> ▪ length of hospital stay
> ▪ physician time

Literature:

Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients, Bruce Leff 1, Lynda Burton, Scott L Mader, Bruce Naughton, Jeffrey Burl, Sharon K Inouye, William B Greenough 3rd, Susan Guido, Christopher Langston, Kevin D Frick, Donald Steinwachs, John R Burton
Affiliations expand

- PMID: 16330791
- DOI: 10.7326/0003-4819-143-11-200512060-00008

Background: Acutely ill older persons often experience adverse events when cared for in the acute care hospital.
Objective: To assess the clinical feasibility and efficacy of providing acute hospital-level care in a patient's home in a hospital at home.
Participants: 455 community-dwelling elderly patients who required admission to an acute care hospital for community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis.
Intervention: Treatment in a hospital-at-home model of care that substitutes for treatment in an acute care hospital.
Measurements: Clinical process measures, standards of care, clinical complications, satisfaction with care, functional status, and costs of care.
Results: Hospital-at-home care was feasible and efficacious in delivering hospital-level care to patients at home. In 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care; in the third site, 29% of patients chose hospital-at-home care. Although less procedurally oriented than acute hospital care, hospital-at-home care met quality standards at rates similar to those of acute hospital care. On an intention-to-treat basis, patients treated in hospital-at-home had a shorter length of stay (3.2 vs. 4.9 days) ($P = 0.004$), and there was some evidence that they also had fewer complications. The mean cost was lower for hospital-at-home care than for acute hospital care (5081 dollars vs. 7480 dollars) ($P < 0.001$).
Conclusions: The hospital-at-home care model is feasible, safe, and efficacious for certain older patients with selected acute medical illnesses who require acute hospital-level care. Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition t

Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients. Am J Manag Care. 2020 Feb 1;26(2):e57-e63. doi: 10.37765/ajmc.2020.42402.

https://pubmed.ncbi.nlm.nih.gov/32059101/
The Common Attributes of Successful Care Manager Programs for High-Need, High-Cost Persons: A Cross-Case Analysis. Ambul Care Manage. 2019 Oct/Dec;42(4):230-241. doi:0.1097/JAC.0000000000000305.PMID: 31449160

https://pubmed.ncbi.nlm.nih.gov/31449160/
Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals. November 10, 2015. The American Journal of Managed Care, November 2015, Volume 21, Issue 11

https://pubmed.ncbi.nlm.nih.gov/26735292/" https://pubmed.ncbi.nlm.nih.gov/26735292/

Summary: Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition to outside of traditional face-to-face office visits.

Therefore, the panel believes that compelling evidence has been met.

Discussion 99437
The expert panel reviewed the new CPT code 99437 which is an add-on code to 99491 and is reported for each additional 30 minutes of QHP time spent on CCM per calendar month.

The survey had 48 respondents, 94% of whom found the vignette to be typical. The median time was 30 minutes and the median work RVU was 1.29 while the 25th percentile work RVU was 1.00. The two key reference services were G0181, and 99498, *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)*. G0181 has times 10/32/15/57 and work RVUs of 1.73 and 99498 has times 0/30/0/30 and work of RVUs 1.40

The expert panel agreed that the median time of 30 minutes and the 25th percentile work RVU of 1.00 placed 99437 in proper rank order to 99491 and the other CCM codes. Specifically, the time of 30 minutes for 99437 is identical to that of 99498 the 25th percentile survey work RVU of 1.00 is 71% the work RVU of 99498 which is appropriate considering that 99498 is a care planning service that is reported when there are family disagreements and multiple family members with whom discussion is needed. Similarly, 30 minutes for 99437 is 0.52% the total time of G0181 and the survey 25th percentile work RVU of 1.00 is 0.58% the work RVU for G0181.

In comparing the recommendations for 99491 and 99437, the expert panel noted that 30 minutes was appropriate given the code requirement of 30 minutes of QHP time and that the work RVU of 1.00, which is 67% of the work RVU for 99491, is appropriate given the relative intensities of the two services. This is also reflected in the relative IWPUTs for these two services of 0.045 and 0.033, respectively.

Therefore, the expert panel recommends the median time of 30 minutes and the 25th percentile work RVU of 1.00 for 99437.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99491	XXX	1.50	0	35	0
4.	+99437	ZZZ	0.95	0	30	0
5.	Total		2.45	0	65	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99491

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See associated frequency spreadsheet) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 115418
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumed to be three times estimated Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 38,473 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated Medicare utilization assumed to be 80% of 99490, based on 99489 as percent of 99487

Specialty (See associated frequency spreadsheet) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99491

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99487 Tracking Number Original Specialty Recommended RVU: **1.81**
Presented Recommended RVU: **1.81**
Global Period: XXX Current Work RVU: **1.00** RUC Recommended RVU: **1.81**

CPT Descriptor: Complex chronic care management services, with the following required elements:

• multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
• chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
• comprehensive care plan established, implemented, revised, or monitored,
• moderate or high complexity medical decision making;

first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
(Adult) An 83-year-old woman with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program and sees a cardiologist and neurologist.

(Child) A 6-year-old boy with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airway disease, chronic seizure disorder, failure to thrive and severe neurodevelopment delay. He receives home occupational, physical and speech therapy services.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Complex chronic care coordination services are patient centered management and support services provided by physicians, other qualified health care professionals, and clinical staff to an individual who resides at home or in a domiciliary, rest home, assisted living facility, or nursing home. This service typically involves 60 minutes of clinical staff time implementing a care plan directed by the physician or other qualified health care professional, per calendar month. This service addresses the coordination of care by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living. Patients who require complex chronic care coordination services may be identified by algorithms that utilize reported conditions and services (e.g. predictive modeling risk score or repeat admissions or emergency department use) or by clinician judgment. Typical patients have two or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation or decompensation or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. Patients may have medical and psychiatric behavioral co-morbidities (e.g. dementia and chronic

obstructive pulmonary disease or substance abuse and diabetes) that complicate their care. Social support weaknesses or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are expected. Medical decision making as defined in the Evaluation and Management (E/M) guidelines is not only applied to the face-to-face services but is determined by the nature of the problems addressed by the reporting individual during the month. A plan of care should be documented and shared with the patient and/or caregiver.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2020					
Presenter(s):	Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA					
Specialty Society(ies):	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA					
CPT Code:	99487					
Sample Size:	28190	**Resp N:**	51			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**5.00**	30.00	500.00	
Survey RVW:	0.43	1.81	**2.10**	2.50	100.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	1.00	30.00	**45.00**	60.00	90.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99487	**Recommended Physician Work RVU: 1.81**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0181	XXX	1.73	**CMS Time File**

CPT Descriptor Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99226	XXX	2.00	**RUC Time**

CPT Descriptor Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99335	XXX	1.72	**RUC Time**	1,241,609

CPT Descriptor 1 Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization

99239	XXX	1.90	**RUC Time**	5,189,830

CPT Descriptor 2 Hospital discharge day management; more than 30 minutes

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 23.5 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 15.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99487	**Top Key Reference CPT Code:** G0181	**2nd Key Reference CPT Code:** **99226**
Median Pre-Service Time	0.00	10.00	10.00
Median Intra-Service Time	45.00	32.00	30.00
Median Immediate Post-service Time	0.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**57.00**	**55.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	10%	25%	30%	35%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	40%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	30%	65%
Physical effort required	10%	50%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	30%	70%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	75%	25%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	50%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	10%	45%	45%
Physical effort required	10%	50%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	30%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Compelling Evidence

The panel considered whether there was compelling evidence for an increase in work RVUs for the CCM codes. The panel reviewed a number of articles on how medical care is shifting from the office to the home.

As evidenced by the included literature:

CCM has significantly increased in complexity because complex medical conditions can now more often be managed while the patient is at home instead of during face-to-face services. For example, services to patients with heart failure, diabetes, and autoimmune disorders can be provided by, or under the supervision of, QHP while the patient is at home in order to decrease emergency department visits, hospitalizations, and placement in nursing homes and to improve quality of life. This shift occurred before COVID-19, was accelerated by COVID-19, and will continue after COVID-19.

The shift to caring for sicker, more complex patients began a little more than ten years ago, shortly before the CCM codes were established. The rapid evolution of sophisticated tools such as remote monitoring apps, self-management apps, ability for patients to transmit complex data (e.g., high resolution photographs) in real time has increased the ability to care for patients remotely. Development of robust remote monitoring technologies (e.g., measurement of pulmonary artery pressures via permanently

implanted sensors, continuous monitoring of vital signs by sensors that are able to transmit data over the internet in real-time) also enables clinicians to make diagnoses and alter treatment regimens without needing to see a patient face-to-face.

Clinicians can now often stratify patients according to risk remotely so that they have time to properly care for those patients who require office visits. This can mean that some patients are now contacted daily instead of weekly. The need to recognize and treat mental health issues has also increased as more and more evidence demonstrates that psychosocial issues play a major role in the treatment of chronic disease and contact with family members and caregivers is essential to help keep these patients functional and able to live at home.

The COVID-19 pandemic has accelerated this transformation and increased the number and complexity of patients needing CCM in order to keep them out of the hospital and to identify those patients who are deteriorating and need admission. COVID-19 has also highlighted the need for physicians to continually counsel patients on lifestyle choices that go far beyond the usual advice regarding exercise and diet. While the need to counsel on socially distancing and wearing a mask may be temporary, the heightened awareness of how all our patients' choices can influence disease management is a permanent addition to the matters in which QHPs and their clinical staff interact with patients.

In summary, the complexity of CCM has significantly increased since the codes were established.

Specifically, the CCM codes meet the following RUC criterion for compelling evidence:

> Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
> ▪ technique
> ▪ **knowledge/technology**
> ▪ **patient populations**
> ▪ site-of-service
> ▪ length of hospital stay
> ▪ physician time

Literature:

1.) Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients, Bruce Leff 1, Lynda Burton, Scott L Mader, Bruce Naughton, Jeffrey Burl, Sharon K Inouye, William B Greenough 3rd, Susan Guido, Christopher Langston, Kevin D Frick, Donald Steinwachs, John R Burton Affiliations expand

- PMID: 16330791
- DOI: 10.7326/0003-4819-143-11-200512060-00008

Background: Acutely ill older persons often experience adverse events when cared for in the acute care hospital.
Objective: To assess the clinical feasibility and efficacy of providing acute hospital-level care in a patient's home in a hospital at home.
Participants: 455 community-dwelling elderly patients who required admission to an acute care hospital for community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis.
Intervention: Treatment in a hospital-at-home model of care that substitutes for treatment in an acute care hospital.
Measurements: Clinical process measures, standards of care, clinical complications, satisfaction with care, functional status, and costs of care.
Results: Hospital-at-home care was feasible and efficacious in delivering hospital-level care to patients at home. In 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care; in the third site, 29% of patients chose hospital-at-home care. Although less procedurally oriented than acute hospital care, hospital-at-home care met quality standards at rates similar to those of acute hospital care. On an intention-to-treat basis, patients treated in hospital-at-home had a shorter length of stay (3.2 vs. 4.9 days) ($P = 0.004$), and there was some evidence that they also had fewer complications. The mean cost was lower for hospital-at-home care than for acute hospital care (5081 dollars vs. 7480 dollars) ($P < 0.001$).
Conclusions: The hospital-at-home care model is feasible, safe, and efficacious for certain older patients with selected acute medical illnesses who require acute hospital-level care. Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition t

2.) Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients. Am J Manag Care. 2020 Feb 1;26(2):e57-e63. doi: 10.37765/ajmc.2020.42402.

https://pubmed.ncbi.nlm.nih.gov/32059101/

3.) The Common Attributes of Successful Care Manager Programs for High-Need, High-Cost Persons: A Cross-Case Analysis. Ambul Care Manage. 2019 Oct/Dec;42(4):230-241. doi:0.1097/JAC.0000000000000305.PMID: 31449160

https://pubmed.ncbi.nlm.nih.gov/31449160/

4.) Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals. November 10, 2015. The American Journal of Managed Care, November 2015, Volume 21, Issue 11

https://pubmed.ncbi.nlm.nih.gov/26735292/" https://pubmed.ncbi.nlm.nih.gov/26735292/

Summary: Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition to outside of traditional face-to-face office visits.

Therefore, the panel believes that compelling evidence has been met.

Discussion 99487

The expert panel reviewed 99487, *Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.*; and 99489, *Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)*.

The survey for 99487 had 51 respondents, 92% of whom found the vignette to be typical and the survey for 99489 also had 51 respondents of whom 96% found the vignette to be typical.

The current time (all intra) and work RVU for 99487 are 26 minutes and 1.00 which are the 25th percentile values from the 2012 survey. The median and 25th percentile current survey times were 45 and 30 minutes, and the median and 25th percentile current survey work RVUs were 2.10 and 1.81. The two key reference services were G0181 and 99226, *Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit*. G0181 has times 10/32/15/57 and work RVU 1.73 and 99226 has times 10/30/15/55 and work RVU of 2.00.
The panel noted that the median survey time of 45 minutes placed it in proper rank order with the median survey time of 99490 which is 25 minutes and that the work value of 99487 should reflect that difference. The panel also noted that 99490 and 99487 are reported based on staff time (not QHP time) and that there did not appear to be any overlap between staff and QHP time. The higher time also reflected the more complex patient population for whom 99487 is furnished.

Therefore, the expert panel agreed that the 25th percentile work RVU of 1.81 was appropriate. This also places 99487 in proper rank order with the two key reference services. G0181 describes a similar but less intensive service in that the patient is under the care of a home health agency, which shares responsibility for patient management with the physician and does not require interaction with caregivers or a moderate level of QHP medical decision making. Therefore, even though the survey median time of 47 minutes is less than the total time for G0181and the survey 25th percentile work RVU of 1.81 is higher than that of G0181, it places the two codes in proper rank order. Similarly, 99226, which is for subsequent observation care has 22% longer total time than the 99487 but 67% less intraservice time then the median survey time for 99487 and its work RVU (2.00) is 10% higher than the survey 25th percentile work RVU for 99487 which places the two in proper rank order - 99226 has long total time and a higher work RVU but also has less intra time than 99487 which means the work RVU of 99487 should reflect the lower total time but much higher intra time. The resultant IWPUT of 0.040 is slightly higher than the current IWPUT.

Therefore, the expert panel recommends the median time of 45 minutes and the 25th percentile work RVU of 1.81 for 99487.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99487

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See associated frequency spreadsheet) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 793257
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumed to be three times estimated Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 264,419 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99487

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99489 Tracking Number Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: ZZZ Current Work RVU: **0.50** RUC Recommended RVU: **1.00**

CPT Descriptor: Complex chronic care management services, with the following required elements:

• multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
• chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
• comprehensive care plan established, implemented, revised, or monitored,
• moderate or high complexity medical decision making;

each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
(Adult) An 83-year-old woman with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program and sees a cardiologist and neurologist.

[Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 99487.]

(Child) A 6-year-old boy present with spastic quadriplegia, gastrostomy tube dependence, gastroesophageal reflux with recurrent bouts of aspiration pneumonia, reactive airway disease, chronic seizure disorder, failure to thrive and severe neurodevelopmental delay. He has already received 89 minutes of clinical staff complex care management services during the calendar month and requires additional clinical staff complex care management services during the same calendar month.

[Note: This is an add-on service. Only consider the additional physician/QHP work beyond the work separately reported with base code 99487.]

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Complex chronic care coordination services are patient centered management and support services provided by physicians, other qualified health care professionals, and clinical staff to an individual who resides at home or in a domiciliary, rest home, assisted living facility, or nursing home. This service typically involves 30

additional minutes of clinical staff time implementing a care plan directed by the physician or other qualified health care professional, per calendar month. This service addresses the coordination of care by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living. Patients who require complex chronic care coordination services may be identified by algorithms that utilize reported conditions and services (e.g. predictive modeling risk score or repeat admissions or emergency department use) or by clinician judgment. Typical patients have two or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation or decompensation or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. Patients may have medical and psychiatric behavioral co-morbidities (e.g. dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care. Social support weaknesses or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are expected. Medical decision making as defined in the Evaluation and Management (E/M) guidelines is not only applied to the face-to-face services but is determined by the nature of the problems addressed by the reporting individual during the month. A plan of care should be documented and shared with the patient and/or caregiver.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA					
Specialty Society(ies):	AAFP, AAHPM, AAP, ACP, ACRh, AGS, AMDA, ANA, AOA					
CPT Code:	99489					
Sample Size:	28190	**Resp N:**	51			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**2.00**	15.00	200.00	
Survey RVW:	0.40	1.00	**1.20**	1.70	20.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	6.00	20.00	**30.00**	35.00	91.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	99489	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0181	XXX	1.73	**CMS Time File**

CPT Descriptor Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99457	XXX	0.61	**RUC Time**

CPT Descriptor Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99407	XXX	0.50	**RUC Time**	83,194

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99308	XXX	1.16	**RUC Time**	11,302,104

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 7 **% of respondents:** 13.7 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 13.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99489	Top Key Reference CPT Code: G0181	2nd Key Reference CPT Code: 99457
Median Pre-Service Time	0.00	10.00	0.00
Median Intra-Service Time	30.00	32.00	20.00
Median Immediate Post-service Time	0.00	15.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**57.00**	**20.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	17%	33%	33%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	50%	33%
Physical effort required	33%	67%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	17%	83%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	40%	60%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	40%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	80%	20%
Physical effort required	20%	60%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	20%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Compelling Evidence

The panel considered whether there was compelling evidence for an increase in work RVUs for the CCM codes. The panel reviewed a number of articles on how medical care is shifting from the office to the home.

As evidenced by the included literature:

CCM has significantly increased in complexity because complex medical conditions can now more often be managed while the patient is at home instead of during face-to-face services. For example, services to patients with heart failure, diabetes, and autoimmune disorders can be provided by, or under the supervision of, QHP while the patient is at home in order to decrease emergency department visits, hospitalizations, and placement in nursing homes and to improve quality of life. This shift occurred before COVID-19, was accelerated by COVID-19, and will continue after COVID-19.

The shift to caring for sicker, more complex patients began a little more than ten years ago, shortly before the CCM codes were established. The rapid evolution of sophisticated tools such as remote monitoring apps, self-management apps, ability for patients to transmit complex data (e.g., high resolution photographs) in real time has increased the ability to care for patients remotely. Development of robust remote monitoring technologies (e.g., measurement of pulmonary artery pressures via permanently

implanted sensors, continuous monitoring of vital signs by sensors that are able to transmit data over the internet in real-time) also enables clinicians to make diagnoses and alter treatment regimens without needing to see a patient face-to-face.

Clinicians can now often stratify patients according to risk remotely so that they have time to properly care for those patients who require office visits. This can mean that some patients are now contacted daily instead of weekly. The need to recognize and treat mental health issues has also increased as more and more evidence demonstrates that psychosocial issues play a major role in the treatment of chronic disease and contact with family members and caregivers is essential to help keep these patients functional and able to live at home.

The COVID-19 pandemic has accelerated this transformation and increased the number and complexity of patients needing CCM in order to keep them out of the hospital and to identify those patients who are deteriorating and need admission. COVID-19 has also highlighted the need for physicians to continually counsel patients on lifestyle choices that go far beyond the usual advice regarding exercise and diet. While the need to counsel on socially distancing and wearing a mask may be temporary, the heightened awareness of how all our patients' choices can influence disease management is a permanent addition to the matters in which QHPs and their clinical staff interact with patients.

In summary, the complexity of CCM has significantly increased since the codes were established.

Specifically, the CCM codes meet the following RUC criterion for compelling evidence:

> Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
> ▪ technique
> ▪ **knowledge/technology**
> ▪ **patient populations**
> ▪ site-of-service
> ▪ length of hospital stay
> ▪ physician time

Literature:

1.) Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients, Bruce Leff 1, Lynda Burton, Scott L Mader, Bruce Naughton, Jeffrey Burl, Sharon K Inouye, William B Greenough 3rd, Susan Guido, Christopher Langston, Kevin D Frick, Donald Steinwachs, John R Burton Affiliations expand

- PMID: 16330791
- DOI: 10.7326/0003-4819-143-11-200512060-00008

Background: Acutely ill older persons often experience adverse events when cared for in the acute care hospital.
Objective: To assess the clinical feasibility and efficacy of providing acute hospital-level care in a patient's home in a hospital at home.
Participants: 455 community-dwelling elderly patients who required admission to an acute care hospital for community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis.
Intervention: Treatment in a hospital-at-home model of care that substitutes for treatment in an acute care hospital.
Measurements: Clinical process measures, standards of care, clinical complications, satisfaction with care, functional status, and costs of care.
Results: Hospital-at-home care was feasible and efficacious in delivering hospital-level care to patients at home. In 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care; in the third site, 29% of patients chose hospital-at-home care. Although less procedurally oriented than acute hospital care, hospital-at-home care met quality standards at rates similar to those of acute hospital care. On an intention-to-treat basis, patients treated in hospital-at-home had a shorter length of stay (3.2 vs. 4.9 days) ($P = 0.004$), and there was some evidence that they also had fewer complications. The mean cost was lower for hospital-at-home care than for acute hospital care (5081 dollars vs. 7480 dollars) ($P < 0.001$).
Conclusions: The hospital-at-home care model is feasible, safe, and efficacious for certain older patients with selected acute medical illnesses who require acute hospital-level care. Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition t

2.) Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients. Am J Manag Care. 2020 Feb 1;26(2):e57-e63. doi: 10.37765/ajmc.2020.42402.

https://pubmed.ncbi.nlm.nih.gov/32059101/

3.) The Common Attributes of Successful Care Manager Programs for High-Need, High-Cost Persons: A Cross-Case Analysis. Ambul Care Manage. 2019 Oct/Dec;42(4):230-241. doi:0.1097/JAC.0000000000000305.PMID: 31449160

https://pubmed.ncbi.nlm.nih.gov/31449160/

4.) Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals. November 10, 2015. The American Journal of Managed Care, November 2015, Volume 21, Issue 11

https://pubmed.ncbi.nlm.nih.gov/26735292/" https://pubmed.ncbi.nlm.nih.gov/26735292/

Summary: Successful management of the highly complex (high-need, high-cost) patients requires team based care that is in addition to outside of traditional face-to-face office visits.

Therefore, the panel believes that compelling evidence has been met.

Discussion 99489
The panel reviewed 99489 which has a total time of 13 minutes (all intra) and a work RVU of 0.50. The survey had 25th percentile and median survey times of 20 and 30, and 25th percentile and median work RVUs of 1.00 and 1.20. The two key reference services were G0181 and 99457, *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes*. G0181 has times 10/32/15/57 and work RVUs of 1.73 and 99457 has times 0/20/0/20 and work RVUs of 0.61. The expert panel agreed that the survey median time of 30 minutes was appropriate because patients who require the provision of such extensive CCM services are sicker and more complex than patients who do not require the extra time. In addition, 30 minutes is 66% of 45 minutes, the survey median time for 99487 which the panel agreed was appropriate. The panel then agreed that the survey 25th percentile work RVU of 1.00 was appropriate and it is 55% of the recommended work RVU for 99487 (1.81). In addition, the resulting IWPUT 0.033, which is lower than the current IWPUT of 0.038, is on the low side for E/M services but appropriate given the survey results. The 25th percentile work RVU of 1.00 is 64%% higher than the work RVU for 99457 which is consistent with the 30 minutes of total (intra) time which is 50% higher than that of 99457.

Lastly the panel compared the recommendations for 99487 and 99489 with those for 99490 and 99439. The panel agreed that the recommendations for these four codes placed them in proper rank order.

Therefore, the expert panel recommends the survey median time of 30 minutes and the survey 25th percentile work RVU of 1.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 3.

3. Code Global Work RVU Pre-Time Intra-Time Post-Time

4.	99487 XXX	1.80	0	48	0
5.	+99489 ZZZ	0.73	0	30	0
6.	Total	2.53	0	78	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99489

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty (See associated frequency spreadsheet) How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 633990
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Assumed to be three times the estimated Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 211,330 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization

Specialty (See associated frequency spreadsheet) Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99489

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99424 Tracking Number BB1 Original Specialty Recommended RVU: **1.45**
Presented Recommended RVU: **1.45**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **1.45**

CPT Descriptor: Principal care management services, for a single high-risk disease, with the following required elements:
•one complex chronic condition expected to last at least 3 months,
•the condition places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
• the condition requires development or revision of disease-specific care plan,
•the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities,
•ongoing communication and care coordination between all practitioners furnishing care;
first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a single complex chronic condition that places the patient at significant risk of decompensation.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Principal care management represents services which focus on the medical and/or psychological needs manifested by a single complex chronic condition expected to last at least three months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease. Code 99424 is reported for at least 30 minutes of physician or other qualified health care professional personal time in care management activities during a calendar month. Principal care management services are disease specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other qualified health care professional is providing single disease rather than comprehensive care management. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.
A physician or other qualified health care professional personally provides these principal care management (PCM) services, which are management and support services, to a patient with a single high-risk disease residing at home or in a domiciliary, rest home, or assisted living facility.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021
Presenter(s):	Phillip E. Rodgers, MD FAAHPM; Marianna Spanaki, MD, PhD, FAAN; Steven Krug, MD, FAAP; Tanvir Hussain, MD, MBA, MHS, MSc, FACP; Fredrica Smith, MD; Audrey Chun, MD; Charles Crecelius, MD, PhD, CMD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Joseph Schlecht, DO
Specialty Society(ies):	American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American College of Physicians, American College of Rheumatology, American Geriatrics Society, AMDA-The Society for Post-Acute and Long-Term Care Medicine, American Nurses Association, American Osteopathic Association
CPT Code:	99424
Sample Size: 22551	**Resp N:** 53
Description of Sample:	A random sampling of active US members from each specialty society.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**10.00**	32.00	1000.00
Survey RVW:	0.40	1.45	**1.73**	2.00	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	30.00	**32.00**	42.00	3696.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99424	**Recommended Physician Work RVU: 1.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**32.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99226	XXX	2.00	**RUC Time**

CPT Descriptor Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0181	XXX	1.73	**CMS Time File**

CPT Descriptor Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99232	XXX	1.39	**RUC Time**	44,656,174

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's

and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99309	XXX	1.50	**RUC Time**	10,009,767

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 14.8 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 12.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 99424	**Top Key Reference CPT Code:** 99226	**2nd Key Reference CPT Code:** **G0181**
Median Pre-Service Time	0.00	10.00	10.00
Median Intra-Service Time	32.00	30.00	32.00
Median Immediate Post-service Time	0.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**32.00**	**55.00**	**57.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	13%	0%	62%	25%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	50%	27%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	25%	38%	37%
Physical effort required	38%	62%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	37%	50%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	29%	29%	28%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	43%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	58%	42%
Physical effort required	14%	72%	14%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and	0%	43%	57%

judgment of physician
- Estimated risk of malpractice suit with poor outcome

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Principal Care Management (PCM)

The expert panel reviewed the four new PCM codes.

As with CCM, two of the codes are reported based on clinical staff time spent on PCM under QHP supervision, one for the first 30 minutes of clinical staff time (99426) and a second for additional 30 minutes of clinical staff time (99427); the other two codes are based on QHP time spent performing PCM, one for the first 30 minutes of QHP time (99424) and a second for each additional 30 minutes of QHP time (99425).

The codes for the initial 30 minutes of time (one for clinical staff time spent under QHP supervision and the other for QHP time) are duplicates of two G codes CMS created (G2064 and 20265) and which became effective on January 1, 2020. In this connection, the panel noted that CMS valued these two G codes based on crosswalks to existing CCM codes.

G2064, the code for QHP PCM, first thirty minutes per calendar month has a time of 30 minutes (all intra) and a work RVU of 1.45 which are crosswalks from 99491. This will become 99424.

G2065, the code for clinical staff PCM performed under QHP supervision, first 30 minutes per calendar month, has a time of 30 minutes (which is not a crosswalk because the code requirement is for 30 minutes of clinical staff time) and a work RVU of 0.61 which is a crosswalk from 99490. This will become 99426.

99424
The panel reviewed 99424. There were 53 respondents, 92% of whom found the vignette to be typical. The survey median time was 32 minutes and the median work RVU was 1.73 while the 25th percentile work RVU was 1.45. The two key reference services were G0181 and 99226, *Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit*. G0181 has times 10/32/15/57 and work RVU of 1.73 and 99226 has times 10/30/15/55 and work RVU of 2.00. The panel also considered its recommendations for 99491, the QHP code for CCM services which are a time of 33 minutes and a work RVU of 1.50.

The panel agreed that the survey median time of 32 minutes was appropriate given that 30 minutes of time are required to report the code and that the 25th percentile for work of 1.45 was also reasonable as it was also slightly less than 25th percentile work RVU for 99491. In other words, the median time of 32 minutes and the 25th percentile work RVU of 1.45 place 99424 in proper rank order with the recommended time and work RVU for 99491. Furthermore, the expert panel reviewed survey data from the 30 respondents to 99424 who also responded to the CCM codes supports these values by noting that the survey median time and survey 25th percentile work RVU from this subset was almost identical to that of the total survey respondents.

More specifically, the survey 25th percentile work RVU for 99424 is 94% of the recommended work RVU for 99491 and the survey median time of 32 minutes is 97% of the survey median time for 99491. This results in an IWPUT of 0.045 which is remarkably similar to that of 99491. The expert panel also looked at the key reference services and agreed that because the intra-service times of those services were similar to the survey median time for 99424, that 1.45 was an appropriate work RVU because it takes into account the lack of pre and post service time in 99424.

Therefore, the expert panel recommends the median survey time of 32 minutes and the 25th percentile work RVU of 1.45.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G2064

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Rheumatology How often? Commonly

Specialty Neurology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 118479
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticiate 3 times the Medicare utilization estimates.

Specialty Internal Medicine Frequency 39493 Percentage 33.33 %

Specialty Rheumatology Frequency 39493 Percentage 33.33 %

Specialty Neurology Frequency 39493 Percentage 33.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 39,493 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The recommendation is based on the Medicare utilization estimates for the 2021 NPRM; data is taken from the 2019 utilization file (code G2064).

Specialty Internal Medicine Frequency 13164 Percentage 33.33 %

Specialty Rheumatology Frequency 13164 Percentage 33.33 %

Specialty Neurology Frequency 13164 Percentage 33.33 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number G2064

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99425 Tracking Number BB2 Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **1.00**

CPT Descriptor: Principal care management services, for a single high-risk disease, with the following required elements:
•one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
•the condition requires development, monitoring, or revision of diseasespecific care plan,
•the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
•ongoing communication and care coordination between relevant practitioners furnishing care; additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a single complex chronic condition that places the patient at significant risk of decompensation.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Principal care management represents services which focus on the medical and/or psychological needs manifested by a single complex chronic condition expected to last at least three months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease. Code 99425 is reported in conjunction with 99424 when at least an additional 30 minutes of physician or other qualified health care professional personal time is spent in care management activities during the calendar month. Principal care management services are disease specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other qualified health care professional is providing single disease rather than comprehensive care management. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.
A physician or other qualified health care professional personally provides these principal care management (PCM) services, which are management and support services, to a patient with a single high-risk disease residing at home or in a domiciliary, rest home, or assisted living facility

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Phillip E. Rodgers, MD FAAHPM; Marianna Spanaki, MD, PhD, FAAN; Steven Krug, MD, FAAP; Tanvir Hussain, MD, MBA, MHS, MSc, FACP; Fredrica Smith, MD; Audrey Chun, MD; Charles Crecelius, MD, PhD, CMD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Joseph Schlecht, DO					
Specialty Society(ies):	American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American College of Physicians, American College of Rheumatology, American Geriatrics Society, AMDA-The Society for Post-Acute and Long-Term Care Medicine, American Nurses Association, American Osteopathic Association					
CPT Code:	99425					
Sample Size:	22581	**Resp N:**	47			
Description of Sample:	A random sampling of active US members from each specialty society.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	10.00	500.00
Survey RVW:	0.38	1.00	**1.50**	1.88	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	20.00	**30.00**	36.00	3696.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	99425	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0181	XXX	1.73	**CMS Time File**

CPT Descriptor Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99498	ZZZ	1.40	**RUC Time**

CPT Descriptor Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure).

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99231	XXX	0.76	**RUC Time**	6,736,945

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

Most Recent

MPC CPT Code 2	Global	Work RVU	Time Source	Medicare Utilization
99308	XXX	1.16	**RUC Time**	11,302,104

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 16.6 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 10.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99425	**Top Key Reference CPT Code:** G0181	**2nd Key Reference CPT Code:** **99498**
Median Pre-Service Time	0.00	10.00	0.00
Median Intra-Service Time	30.00	32.00	30.00
Median Immediate Post-service Time	0.00	15.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**57.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**

Overall intensity/complexity	0%	0%	38%	25%	37%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	63%	37%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	12%	38%	50%
Physical effort required	12%	63%	25%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

2nd Key Reference Code

	Much Less	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	50%	33%	0%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	50%	33%	17%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	17%	50%	33%
Physical effort required	0%	83%	17%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Principle Care Management (PCM)
The expert panel reviewed the four new PCM codes.

As with CCM, two of the codes are reported based on clinical staff time spent on PCM under QHP supervision, one for the first 30 minutes of clinical staff time (99426) and a second for additional 30 minutes of clinical staff time (99427); the other two codes are based on QHP time spent performing PCM, one for the first 30 minutes of QHP time (99424) and a second for each additional 30 minutes of QHP time (99425).

The codes for the initial 30 minutes of time (one for clinical staff time spent under QHP supervision and the other for QHP time) are duplicates of two G codes CMS created (G2064 and 20265) and which became effective on January 1, 2020. In this connection, the panel noted that CMS valued these two G codes based on crosswalks to existing CCM codes.

G2064, the code for QHP PCM, first thirty minutes per calendar month has a time of 30 minutes (all intra) and a work RVU of 1.45 which are crosswalks from 99491. This will become 99424.

G2065, the code for clinical staff PCM performed under QHP supervision, first 30 minutes per calendar month, has a time of 30 minutes (which is not a crosswalk because the code requirement is for 30 minutes of clinical staff time) and a work RVU of 0.61 which is a crosswalk from 99490. This will become 99426.

99425

The panel reviewed the survey for 99425 which had 47 respondents, 96% of whom agreed the vignette was typical. The survey median time was 30 minutes which was appropriate for a code that requires 30 minutes of time to report and the survey median work RVU was 1.50 and the survey 25th percentile work RVU was 1.00.

The two key reference services were G0181 and 99498, *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)*.

G0181 has times 10/32/15/57 and work RVU of 1.73 and 99498 has times 0/30/0/30 and a work RVU of 1.40.

The panel agreed that 99425 is a less intense service than 99424 and that it is less intense than 99498 which is an add-on code that describes advance care planning, each additional 30 minutes. The panel also agreed that the intensity of 99425 is not higher than 99437 which is the comparable add-on code for QHP CCM. Therefore, considering that the survey median times of 30 minutes for 99425 and 99437 were identical, the expert panel agreed the survey 25th percentile of 1.00 is appropriate and places 99425 in proper rank order to 99424, 99437, and the two key reference services.

Lastly, the panel reviewed the survey results from the 30 respondents who completed the surveys for all the codes and noted that the survey results from this subset were similar to that of the total survey. Please note that the panel did consider cross walking the recommended work RVU for 99437 of 0.99 to 99425 but decided to recommend the survey results as they were virtually identical.

Therefore, the expert panel recommends the median survey time of 30 minutes and the 25th percentile work RVU of 1.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G2064

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Cardiology How often? Commonly

Specialty Neurology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 29619
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticiate 3 times the Medicare utilization estimates.

Specialty Internal Medicine Frequency 9873 Percentage 33.33 %

Specialty Cardiology Frequency 9873 Percentage 33.33 %

Specialty Neurology Frequency 9873 Percentage 33.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,873
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 25% of the instances of principle care servives will extend beyond the 30 minute threshold of base code 99424, and require reporting 99425. 9,873 is 25% of estimated utilization of base code 99424.

Specialty Internal Medicine Frequency 3291 Percentage 33.33 %

Specialty Cardiology Frequency 3291 Percentage 33.33 %

Specialty Neurology Frequency 3291 Percentage 33.33 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. G2064

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99426 Tracking Number BB3 Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **1.00**

CPT Descriptor: Principal care management services, for a single high-risk disease, with the following required elements;
•one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
•the condition requires development, monitoring, or revision of disease-specific care plan,
•the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities,
•ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a single complex chronic condition that places the patient at significant risk of decompensation.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Principal care management represents services which focus on the medical and/or psychological needs manifested by a single complex chronic condition expected to last at least three months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease. Code 99426 is reported for the first 30 minutes of clinical staff time spent in care management activities during the calendar month. Principal care management services are disease specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other qualified health care professional is providing single disease rather than comprehensive care management.
Management and support services are provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient with a single high-risk disease residing at home or in a domiciliary, rest home, or assisted living facility. These services typically include clinical staff implementing the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis directed by the physician or other qualified health care professional.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021
Presenter(s):	Phillip E. Rodgers, MD FAAHPM; Marianna Spanaki, MD, PhD, FAAN; Steven Krug, MD, FAAP; Tanvir Hussain, MD, MBA, MHS, MSc, FACP; Fredrica Smith, MD; Audrey Chun, MD; Charles Crecelius, MD, PhD, CMD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Joseph Schlecht, DO
Specialty Society(ies):	American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American College of Physicians, American College of Rheumatology, American Geriatrics Society, AMDA-The Society for Post-Acute and Long-Term Care Medicine, American Nurses Association, American Osteopathic Association
CPT Code:	99426
Sample Size: 22581	**Resp N:** 63
Description of Sample:	random sampling of active US members from each specialty society.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**10.00**	58.00	1200.00
Survey RVW:	0.33	1.10	**1.56**	2.00	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	18.00	**30.00**	40.00	3696.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99426	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99226	XXX	2.00	**RUC Time**

CPT Descriptor Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99091	XXX	1.10	**RUC Time**

CPT Descriptor Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99282	XXX	0.93	**RUC Time**	352,496

CPT Descriptor 1 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

Most Recent

MPC CPT Code 2	Global	Work RVU	Time Source	Medicare Utilization
99308	XXX	1.16	**RUC Time**	11,302,104

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 12.6 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 11.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 99426	**Top Key Reference CPT Code:** 99226	**2nd Key Reference CPT Code:** **99091**
Median Pre-Service Time	0.00	10.00	5.00
Median Intra-Service Time	25.00	30.00	30.00
Median Immediate Post-service Time	0.00	15.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**25.00**	**55.00**	**40.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**

Overall intensity/complexity	0%	0%	25%	38%	37%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	50%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	25%	75%
Physical effort required	0%	38%	62%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	38%	62%

2nd Key Reference Code

	Much Less	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	12%	13%	38%	25%	12%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	63%	12%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	37%	50%	13%
Physical effort required	63%	12%	25%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	50%	37%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Principal Care Management (PCM)
The expert panel reviewed the four new PCM codes.

As with CCM, two of the codes are reported based on clinical staff time spent on PCM under QHP supervision, one for the first 30 minutes of clinical staff time (99426) and a second for additional 30 minutes of clinical staff time (99427); the other two codes are based on QHP time spent performing PCM, one for the first 30 minutes of QHP time (99424) and a second for each additional 30 minutes of QHP time (99425).

The codes for the initial 30 minutes of time (one for clinical staff time spent under QHP supervision and the other for QHP time) are duplicates of two G codes CMS created (G2064 and 20265) and which became effective on January 1, 2020. In this connection, the panel noted that CMS valued these two G codes based on crosswalks to existing CCM codes.

G2064, the code for QHP PCM, first thirty minutes per calendar month has a time of 30 minutes (all intra) and a work RVU of 1.45 which are crosswalks from 99491. This will become 99424.

G2065, the code for clinical staff PCM performed under QHP supervision, first 30 minutes per calendar month, has a time of 30 minutes (which is not a crosswalk because the code requirement is for 30 minutes of clinical staff time) and a work RVU of 0.61 which is a crosswalk from 99490. This will become 99426.

99426

The expert panel then reviewed the survey data for 99426, PCM delivered by clinical staff under QHP supervision, first 30 minutes per calendar month (what is now G02065) and 99427, PCM delivered by clinical staff under QHP supervision, each additional 30 minutes per calendar month.

The survey for 99426 had 53 respondents, 94% of whom found the vignette typical and the survey for 99427 had 51 respondents, 94% of whom found the vignette to be typical. The survey for 99426 had a median time of 30 minutes and a median work RVU of 1.56 and a 25th percentile RVU of 1.10.

The key reference services for 99426 were 99091, *Collection and interpretation of physiologic data (e.g. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days*, and 99226. 99091 has times 5/30/5/40 and work RVUs of 1.10 and 99226 has times 10/30/15/55 and work RVUs of 2.00.

The expert panel also considered its recommendations for 99490, the CCM code comparable to 99426, which are the survey median of 25 minutes of time and the survey work RVU of 1.00.

The panel agreed that the survey median time of 30 minutes was appropriate and required by the code descriptor and that the survey 25th percentile work RVU was supported by comparison to 99091 because 99091 has more total time but is less intense than 99426 which involves direct patient care for patients with a deteriorating medical condition over a period of one month. However, the panel also agreed that a work RVU of 1.10 (survey 25th percentile) was too high and would place it out of rank order with 99490 and 99487 in terms of intensity and 99426 should not have a higher work RVU than 99490.

Therefore, the panel agreed that an RVU crosswalk from its recommendation for 99490 of 1.00 work RVU would place 99426 in correct rank order with the key reference services, the clinical staff CCM codes and 99424 which has a QHP time of 32 minutes and work RVU of 1.45. Consistent with this, the resultant IWPUT of 0.040 is less than the IWPUT of 99424 (0.045) and the same as the recommended IWPUT for 99490 (0.040).

Therefore, for CPT 99426 the expert panel recommends a time of 30 minutes which is the survey median and time required by the code and a work RVU of 1.00 which is a crosswalk from the recommendation for 99490.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G2065

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Family Medicine How often? Commonly

Specialty Nurse Practitioner How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 716559
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. 3 times the Medicare utilization estimates

Specialty Internal Medicine Frequency 238853 Percentage 33.33 %

Specialty Family Medicine Frequency 238853 Percentage 33.33 %

Specialty Nurse Practitioner Frequency 238853 Percentage 33.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 238,853 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The recommendation is based on the Medicare utilization estimates for the 2021 NPRM; data is taken from the 2019 utilization file (code G2065).

Specialty Internal Medicine Frequency 79617 Percentage 33.33 %

Specialty Family Medicine Frequency 79617 Percentage 33.33 %

Specialty Nurse Practitioner Frequency 79617 Percentage 33.33 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number G2065

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99427 Tracking Number BB4 Original Specialty Recommended RVU: **0.62**
Presented Recommended RVU: **0.70**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **0.71**

CPT Descriptor: Principal care management services, for a single high-risk disease, with the following required elements;
•one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
•the condition requires development, monitoring, or revision of disease-specific care plan,
•the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities,
•ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a single complex chronic condition that places the patient at significant risk of decompensation.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Principal care management represents services which focus on the medical and/or psychological needs manifested by a single complex chronic condition expected to last at least three months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease. Code 99427 is reported in conjunction with 99X24 when at least an additional 30 minutes of clinical staff time is spent in care management activities during the calendar month. Principal care management services are disease specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other qualified health care professional is providing single disease rather than comprehensive care management.
Management and support services are provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient with a single high-risk disease residing at home or in a domiciliary, rest home, or assisted living facility. These services typically include clinical staff implementing the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis directed by the physician or other qualified health care professional

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021
Presenter(s):	Phillip E. Rodgers, MD FAAHPM; Marianna Spanaki, MD, PhD, FAAN; Steven Krug, MD, FAAP; Tanvir Hussain, MD, MBA, MHS, MSc, FACP; Fredrica Smith, MD; Audrey Chun, MD; Charles Crecelius, MD, PhD, CMD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Joseph Schlecht, DO
Specialty Society(ies):	American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American College of Physicians, American College of Rheumatology, American Geriatrics Society, AMDA-The Society for Post-Acute and Long-Term Care Medicine, American Nurses Association, American Osteopathic Association
CPT Code:	99427
Sample Size: 22581	**Resp N:** 51
Description of Sample:	A random sampling of active US members from each specialty society.

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	20.00	500.00
Survey RVW:	0.30	0.91	**1.20**	1.74	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	14.00	**30.00**	36.00	3696.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	99427	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
G0181	XXX	1.73	**CMS Time File**

CPT Descriptor Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99091	XXX	1.10	**RUC Time**

CPT Descriptor Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99407	XXX	0.50	**RUC Time**	83,194

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99231	XXX	0.76	**RUC Time**	6,736,945

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 15.6 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 11.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99427	Top Key Reference CPT Code: G0181	2nd Key Reference CPT Code: **99091**
Median Pre-Service Time	0.00	10.00	5.00
Median Intra-Service Time	20.00	32.00	30.00
Median Immediate Post-service Time	0.00	15.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**57.00**	**40.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	63%	25%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	63%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	37%	50%
Physical effort required	25%	63%	12%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	50%	17%	16%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	33%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	33%	50%
Physical effort required	0%	67%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Introduction

CPT created four new codes for principal care management (PCM) at the September 2020 CPT meeting. Two of the codes describe principal care management performed by clinical staff under the supervision of a qualified health professional (QHP) and the other two describe principal care management performed by the QHP herself. The PCM codes differ from the chronic care management (CCM) codes in that they are to be reported by QHPs when that professional is responsible for managing a patient's single chronic illness as opposed to being responsible for managing the entire care of a patient with two or more chronic illnesses. Therefore, it is possible that a PCM code will be reported during the same month as a CCM code - albeit by different QHPs.

Because the CCM codes are in the same family as the new PCM codes, the entire code family, CCM, CCCM and PCM, were surveyed. We note that the CCM codes were due to be surveyed in 2019 because they were identified as high growth services but, in consultation with the Research Subcommittee, the surveys were delayed until this cycle so the CCM, CCCM and PCM codes could be surveyed at the same time. The surveying societies were the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Society (AGS), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the American Nurses Association (ANA), the American College of Rheumatology (ACR), the American Academy of Neurology (AAN), the American Association of Hospice and Palliative Care Medicine (AAHPM), and the Society for Post-Acute and Long-Term Care Medicine (AMDA). The surveying societies met with the Research Subcommittee and obtained approval of the survey tool, making the vignettes more general (i.e., similar to those used for the office visit codes), the RSL codes, and combining the XXX and ZZZ codes in a single RSL that did not include the office visit codes.

Background

The CCM survey was randomly distributed to members of the ACP, AAFP, AGS, AOA, ANA AAHPM, AAP, AMDA, and ACR. The PCM survey was randomly distributed to members of AAN and all the above societies except for AAFP. In other words, all societies except for AAFP and AAN surveyed both sets of codes.

The surveying societies convened an expert panel to review the summary data. The panel noted that it was important not only for the CCM and the PCM code sets to be ranked correctly internally, but that the CCM and PCM codes must be ranked correctly to each other. Therefore, the panel looked very closely at the sub analysis survey responses from respondents who responded to both sets of codes in the survey.

The panel noted the low response rates. The panel believes this was mostly due to COVID-19 surges across the US. While the response rates were low, the panel agreed that the survey data appeared valid in terms of the spread of times and work RVUs and did not show any indication of confusion on the part of the respondents.

Principal Care Management (PCM)
The expert panel reviewed the four new PCM codes.

As with CCM, two of the codes are reported based on clinical staff time spent on PCM under QHP supervision, one for the first 30 minutes of clinical staff time (99426) and a second for additional 30 minutes of clinical staff time (99427); the other two codes are based on QHP time spent performing PCM, one for the first 30 minutes of QHP time (99424) and a second for each additional 30 minutes of QHP time (99425).

The codes for the initial 30 minutes of time (one for clinical staff time spent under QHP supervision and the other for QHP time) are duplicates of two G codes CMS created (G2064 and 20265) and which became effective on January 1, 2020. In this connection, the panel noted that CMS valued these two G codes based on crosswalks to existing CCM codes.

G2064, the code for QHP PCM, first thirty minutes per calendar month has a time of 30 minutes (all intra) and a work RVU of 1.45 which are crosswalks from 99491. This will become 99424.

G2065, the code for clinical staff PCM performed under QHP supervision, first 30 minutes per calendar month, has a time of 30 minutes (which is not a crosswalk because the code requirement is for 30 minutes of clinical staff time) and a work RVU of 0.61 which is a crosswalk from 99490. This will become 99426.

99427

The panel reviewed 99427. The two key reference services were 99091, which has times 5/30/5/40 and work RVU of 1.10, and G0181 which has times 10/32/15/57 and a work RVU of 1.73. Although the comparison to 99091 supported the survey median time and 25th percentile work RVU, the expert panel agreed that would create a rank order anomaly because 99427 has a similar intensity to 99439 (currently G2058) the add-on code to 99490.

The panel reviewed the survey RVU data for 99427 and agreed that the survey data for work RVU was too high (median 1.20 and 25th percentile 0.91) and accepting these would put the services out of appropriate ranking with 99439, the comparable CCM code to 99427. Therefore, the expert panel considered a crosswalk to 99439 at 0.70 RVU and 20 minutes of time.

Then panel looked at the survey sub analysis responses to 99427 from the 30 respondents who responded to all the survey codes including 99490. The survey responses from this subset for 99427 were a median time of 21 minutes and a 25th percentile work RVU of 0.62. These values are similar to those from the survey for 99439.

After much consideration, the panel decided to recommend crosswalks for time and work RVU from its recommendations for 99439 which are based on the survey data for 99439.

Therefore, for CPT 99427 the expert panel recommends a time of 20 minutes and a work RVU of 0.70.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) G2065

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine	How often? Commonly
Specialty Family Medicine	How often? Commonly
Specialty Nurse Practitioner	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 179139
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticiate 3 times the Medicare utilization estimates

Specialty Internal Medicine	Frequency 59713	Percentage 33.33 %
Specialty Family Medicine	Frequency 59713	Percentage 33.33 %
Specialty Nurse Practitioner	Frequency 59713	Percentage 33.33 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 59,713 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate 25% of the instances of principle care servives will extend beyond the 30 minute threshold of base code 99X24, and require reporting 99427. 59,713 is 25% of estimated utilization of base code 99X24

Specialty Internal Medicine	Frequency 19904	Percentage 33.33 %
Specialty Family Medicine	Frequency 19904	Percentage 33.33 %
Specialty Nurse Practitioner	Frequency 19904	Percentage 33.33 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number G2065

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

Hospital at Home: Feasibility and Outcomes of a Program To Provide Hospital-Level Care at Home for Acutely Ill Older Patients

Bruce Leff, MD; Lynda Burton, ScD; Scott L. Mader, MD; Bruce Naughton, MD; Jeffrey Burl, MD; Sharon K. Inouye, MD, MPH; William B. Greenough III, MD; Susan Guido, RN; Christopher Langston, PhD; Kevin D. Frick, PhD; Donald Steinwachs, PhD; and John R. Burton, MD

Background: **Acutely ill older persons often experience adverse events when cared for in the acute care hospital.**

Objective: **To assess the clinical feasibility and efficacy of providing acute hospital-level care in a patient's home in a hospital at home.**

Design: **Prospective quasi-experiment.**

Setting: **3 Medicare-managed care (Medicare + Choice) health systems at 2 sites and a Veterans Administration medical center.**

Participants: **455 community-dwelling elderly patients who required admission to an acute care hospital for community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis.**

Intervention: **Treatment in a hospital-at-home model of care that substitutes for treatment in an acute care hospital.**

Measurements: **Clinical process measures, standards of care, clinical complications, satisfaction with care, functional status, and costs of care.**

Results: **Hospital-at-home care was feasible and efficacious in delivering hospital-level care to patients at home. In 2 of 3 sites studied, 69% of patients who were offered hospital-at-home care chose it over acute hospital care; in the third site, 29% of patients chose hospital-at-home care. Although less procedurally oriented than acute hospital care, hospital-at-home care met quality standards at rates similar to those of acute hospital care. On an intention-to-treat basis, patients treated in hospital-at-home had a shorter length of stay (3.2 vs. 4.9 days) ($P = 0.004$), and there was some evidence that they also had fewer complications. The mean cost was lower for hospital-at-home care than for acute hospital care ($5081 vs. $7480) ($P < 0.001$).**

Limitations: **Possible selection bias because of the quasi-experimental design and missing data, modest sample size, and study site differences.**

Conclusions: **The hospital-at-home care model is feasible, safe, and efficacious for certain older patients with selected acute medical illnesses who require acute hospital-level care.**

Ann Intern Med. 2005;143:798-808. www.annals.org

For author affiliations, see end of text.

Although the acute care hospital is the standard venue for providing acute medical care, it is expensive and may be hazardous for older persons, who commonly experience functional decline, iatrogenic illness, and other adverse events during care (1–3). Providing acute hospital-level care in a patient's home is an alternative to hospital care (4, 5). Although several hospital-at-home models have been studied, there is controversy regarding the effectiveness of this method. In part, this reflects heterogeneity among hospital-at-home models (6). A recent Cochrane review examined surgical and medical early hospital discharge models, terminal care, and admission avoidance, that is, substitutive models. Overall, no differences were found in health outcomes. Patients, but not caregivers, had increased satisfaction with hospital-at-home care, and there was some evidence that substitutive models may be cost-effective (7). However, with some exceptions (8), most of these models would be difficult to distinguish from augmented skilled nursing services, community-based long-term care, or home-based primary care services in the United States. In addition, most studies have been done in countries with single-payer national health insurance systems (7–14).

Previous research in the United States has been limited to a pilot study of a physician-led substitutive hospital-at-home model for older persons with acute medical illness (15). The aim of our study was to evaluate the safety, efficacy, clinical and functional outcomes, patient and caregiver satisfaction, and costs of providing acute hospital-level care in a hospital at home that substituted entirely for admission to an acute care hospital for older persons.

Methods

Patients

The target sample was community-dwelling persons, age 65 years and older, who lived in a catchment area and who, in the opinion of a physician not involved in the

See also:

Print

Editors' Notes 799
Editorial comment. 840
Summary for Patients. I-56

Web-Only

Conversion of figure and tables into slides

Improving Patient Care is a special section within *Annals* supported in part by the U.S. Department of Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ). The opinions expressed in this article are those of the authors and do not represent the position or endorsement of AHRQ or HHS.

 © 2005 American College of Physicians

study, required admission to an acute care hospital for 1 of 4 target illnesses: community-acquired pneumonia, exacerbation of chronic heart failure, exacerbation of chronic obstructive pulmonary disease, or cellulitis. Patients were required to meet validated criteria of medical eligibility for hospital-at-home care (16), which were designed to identify patients who would be medically suitable for this type of treatment. The most common reasons for medical ineligibility were uncorrectable hypoxemia (oxygen saturation <90%), suspected myocardial ischemia, and presence of an acute illness, other than the target illness, for which the patient was required to be hospitalized.

Study Design

This study was a prospective quasi-experiment conducted in 2 consecutive 11-month phases. During the acute care hospital observation phase (1 November 1990 to 30 September 2001), eligible patients were identified and followed through usual hospital care. Study coordinators verified the patient's eligibility for hospital-at-home care using a standard protocol at the time of enrollment. During this observation phase of the study, most patients were identified the morning after admission. These patients made up the acute hospital observation comparison group. During the intervention phase (1 November 2001 to 30 September 2002), eligible patients were identified at the time of admission and were offered the option of receiving their care in hospital at home rather than in the acute care hospital. Patients who chose hospital-at-home treatment were never admitted to the acute care hospital but received treatment, after initial evaluation (usually in the emergency department), in their home. The intervention group comprised all patients eligible for hospital-at-home care, irrespective of where they were treated.

Approval

The institutional review boards from each study site, the coordinating center, and officials at the Center for Health Plans and Providers at the Centers for Medicare & Medicaid Services (CMS) gave their approval for the study. All participants provided informed written consent.

Study Sites

The study was conducted in 3 Medicare managed care (Medicare + Choice) plans at 2 sites and at a Veterans Administration medical center. Univera Health and Independent Health, in Buffalo, New York, are Medicare + Choice plans that operate in an independent practice association model. These 2 plans collaborated to provide hospital-at-home care and made up 1 study site (site 1). The Fallon Health Care System (site 2), in Worcester, Massachusetts, operates a not-for-profit Medicare + Choice plan, and the Fallon Clinic, a for-profit multispecialty physician group, provides care on a capitated basis to Medicare + Choice beneficiaries. The Portland, Oregon, Veterans Administration Medical Center (site 3) is a quaternary care and teaching facility.

Context

Hospital care for older people often means iatrogenic complications and a decline in function. Home hospital care might reduce these adverse outcomes.

Content

Patients were 65 years of age or older and required hospital care for pneumonia, heart failure, chronic obstructive pulmonary disease, or cellulitis. In phase I, they were hospitalized. In phase II, they could choose home hospital care (continuous nursing care followed by at least daily visits from a nurse and a physician). Sixty percent of patients chose home hospital care. Patients who received this type of care had shorter stays; fewer procedures, consultations, and indwelling devices; less delirium; greater satisfaction; and similar functional outcomes.

Cautions

The study was nonrandomized, and data were missing.

Conclusion

Home hospital care may be a good alternative for selected patients.

—The Editors

Assessments

Age, gender, and primary diagnosis were obtained for all eligible patients. Informed written consent was required for all additional data collection: medical record review, cost data review, and interviews. Staff trained at the coordinating center used standard procedures outlined in a detailed training manual to conduct all interviews, assessments, and medical record reviews. At baseline, interrater reliability was verified among the staff. Quality checks of medical record reviews were done midway through the study. Interrater reliability for ratings on the components of the daily patient interview was confirmed in 13 paired observations ($\kappa = 0.91$). Interrater reliability among study sites was similar.

Medical Record Reviews

Medical records were abstracted by using a standardized instrument that captured illness acuity, health status, medication use, results of laboratory tests, treatments, the hospital course and complications, health outcomes, and whether treatment standards were met. Illness acuity was determined by using the Acute Physiology and Chronic Health Evaluation II (APACHE II) score (17). Health status was measured by using clinical indicators appropriate to the diagnoses, a checklist of chronic medical conditions, and the Charlson comorbidity index (18). Medication use was defined as the number of prescribed medications taken on a daily basis at the time of admission. Diagnostic and therapeutic interventions were categorized as potentially "difficult" or "not difficult" to do in the home. The patient's clinical course was characterized according to

whether emergency situations (those that required physician evaluation within 30 minutes, such as the development of acute shortness of breath) or critical complications (death, transfer to intensive care setting, intubation, or myocardial infarction) occurred. Clinical care was examined with regard to completion of illness-specific standards of care (19–21).

Eligible patients who consented to participate completed a baseline interview that included demographic information, self-reported health status, assessment of sleep, Katz activities (22), Lawton instrumental activities of daily living (23), continence, mobility, the Geriatric Depression Scale (24), Jaeger vision test, the Mini-Mental State Examination (MMSE) (25), the Digit Span Test (26), and evaluation by the Confusion Assessment Method (CAM) (27). Subsequently, patients were evaluated daily until discharge by using a structured interview consisting of the MMSE, Digit Span Test, and CAM rating. A family member, caregiver, or person who knew the patient well was interviewed at the time of admission to complete the modified Blessed Dementia Rating Scale (28). At 2 weeks after admission, patients and family members were interviewed by telephone to obtain the patient's current functional status and to assess his or her satisfaction with care.

Intervention: The Hospital-at-Home Model of Care

The hospital-at-home model of care has been described previously (15). Briefly, a patient requiring admission to the acute care hospital for a target illness was identified in an emergency department or ambulatory site and his or her eligibility status was determined. Nonstudy medical personnel, usually emergency department physicians, made the decision to hospitalize the patient. All patients who were offered but who declined hospital-at-home care were admitted to the acute care hospital.

After informed consent was obtained, the patient was transported home by an ambulance. Patients were evaluated by the hospital-at-home physician either in the emergency department or shortly after arriving at home. Patients who required oxygen therapy were sent home with a portable oxygen apparatus pending delivery of home oxygen therapy. The hospital-at-home nurse met the ambulance at the patient's home. The patient had subsequent direct one-on-one nursing supervision for an initial period of at least 8 hours at site 3 and for a period of 24 hours at sites 1 and 2.

When direct nursing supervision was no longer required, the patient had intermittent nursing visits at least daily. The hospital-at-home physician made at least daily home visits and was available 24 hours a day for urgent or emergent visits. Nursing and other care components, such as durable medical equipment, oxygen therapy, skilled therapies, and pharmacy support, were provided by a partner Medicare-certified home health agency, and for some services, such as home radiology, support was provided by independent contractors. A Lifeline device (Lifeline Systems Inc., Framingham, Massachusetts) was placed in the home of any patient who did not have a family member present. Diagnostic studies, such as electrocardiography and radiography; intravenous fluids, intravenous antimicrobial agents, and other medications; and oxygen and other respiratory therapies were provided at home. Illness-specific hospital-at-home care maps, clinical outcome evaluations, and specific discharge criteria were developed and provided a pathway for care. The patient was followed by the same hospital-at-home physician until his or her condition was stable enough for discharge, at which time care reverted to the primary care physician.

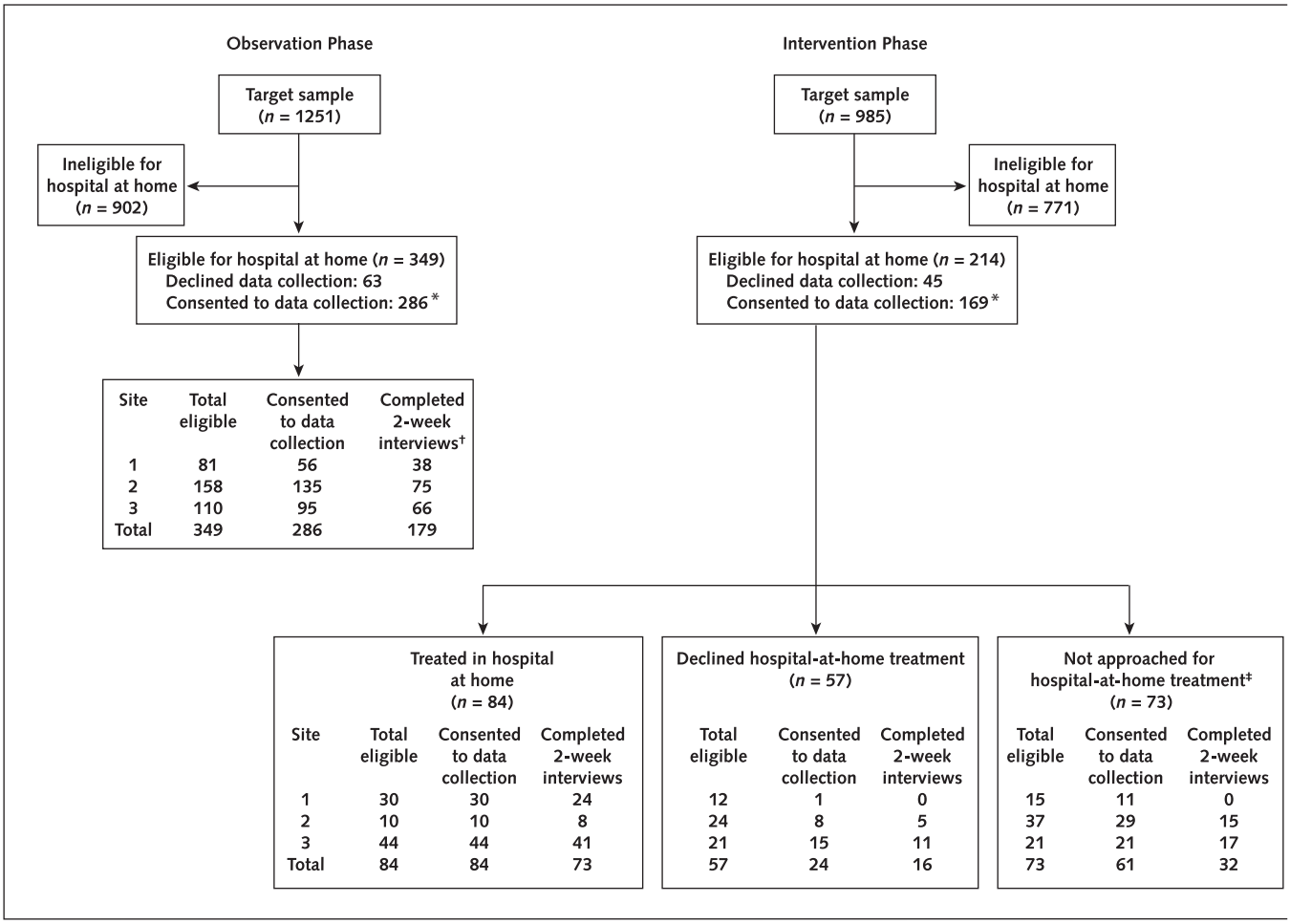
Outcomes

Process-of-care measures included time to first physician visit in the home, arrival of the nurse, and delivery of oxygen or medications. Additional process outcomes included hours of one-on-one nursing supervision, mean number of physician and intermittent nursing visits, treatments received, use of consultative services, and whether illness-specific standards of care were met.

Clinical outcomes included emergency situations and critical complications and various complications, including incident delirium. Incident delirium was defined as the acute onset and fluctuating course of symptoms of delirium, inattention, and either disorganized thinking or an altered level of consciousness according to the CAM criteria (27). Subsyndromal delirium was defined as the acute onset and fluctuating course of symptoms of delirium and either inattention or disorganized thinking or an altered level of consciousness (29). Each CAM feature was rated by study nurses on the basis of observations made during daily interviews. Incident delirium was defined as present or absent. Adjudication of delirium ratings was done by 2 independent reviewers who were unaware of the participant's study group. Satisfaction with care was measured by using a modified Picker Hospital Survey (30). A summary score was derived based on satisfaction with admission and discharge processes; relations with physician, nurses, and staff; and safety, comfort, and pain control (patients only). Possible scores ranged from 0 to 9 and 0 to 8 for patients and family members, respectively. Functional status was measured by using a summary score for activities of daily living (range, 0 to 5) and for instrumental activities of daily living (range, 0 to 7).

Costs of care were calculated. In the Medicare + Choice settings, we obtained data from the managed care organizations on the total amounts paid by the plan and by the patients during the index hospitalization in either the acute care hospital or the hospital-at-home setting. For the Veterans Administration medical center, we obtained an estimate of the costs of each patient's care based on a step-down approach that allocates overhead charges in addition to the costs of care directly associated with the patient. We chose to use these amounts to focus on the cost for which

Figure. **Patient flow and data availability by study phase and site.**



* Consented at least to medical record review and review of cost data. † Consented to review of medical records and cost data and completed baseline interview and 2-week follow-up interview. ‡ Not approached for hospital-at-home treatment because hospital at home was not open for admissions between 10:00 p.m. and 6:00 a.m.

each payer in the current financing system was responsible. For hospital-at-home care, the costs of staff were included.

Safety Monitoring

Each of the study sites convened a patient safety committee that reviewed hospital-at-home cases. A Coordinating Center Data Safety Monitoring Board met 3 times during the intervention phase.

Statistical Analysis

We conducted exploratory analyses to examine all baseline demographic and health status characteristics at each study site. A priori, we conducted a pooled analysis of participants from the 3 study sites. In addition, we calculated the results from individual study sites.

All analyses were done on an intention-to-treat basis, in which participants from the observation group who were treated in the acute care hospital were compared with participants in the intervention group, regardless of whether they were treated in hospital at home or in the acute care hospital. A complete-case analysis was conducted and assumed that data were missing completely at random. The respective proportion of participants in the observation and intervention groups across study sites who consented to review of costs and medical records (82% vs. 78%), who consented to the baseline interview (66% vs. 67%), and who completed a 2-week follow-up telephone interview (51% vs. 57%) were similar. Thus, this assumption seemed reasonable, although for end points with substantial amounts of missing data, such as incident delirium, satisfaction with care, and function, bias cannot be ruled out and results must be interpreted cautiously.

We evaluated the effect of the intervention on clinical complications by using logistic regression for dichotomous variables with sufficient numbers of events; otherwise, the Fisher exact test is reported. We dichotomized a variable for site comparing site 2 versus sites 1 and 3. This was justified because relatively few participants in the intervention phase received actual hospital-at-home care at site 2. The unadjusted model examines the effect of the interven-

tion. We then controlled for study phase and the interaction between site and study phase. The interaction term was never statistically significant and thereafter was not included as a covariate. In the adjusted model, the following covariates were added on the basis of differences in participant characteristics and factors that we postulated could influence clinical outcomes: age, gender, APACHE II score, and study site.

The analysis of incident delirium was limited to participants who did not have prevalent delirium at the time of admission and who had 2 or more CAM assessments: 173 patients in the observation group and 127 in the intervention group. There were no differences in delirium risk factor profiles between patients with 2 or more CAM assessments and those with only 1 CAM assessment. A proportional hazards model, as well as Kaplan–Meier analysis and the log-rank test, were used to compare the cumulative incidence of delirium, which was defined as the probability that delirium would develop by a specified time. Assumptions of the proportional hazards model were tested and were met. A similar approach was taken for covariate selection as for other outcomes, except for the inclusion of additional specific delirium risk factors of visual impairment, cognitive impairment, and dehydration.

Satisfaction data were explored. Differences in the median number of domains in which patients or caregivers were satisfied were examined by study phase by using Wilcoxon rank-sum tests. To test for the effect of covariates, scores were dichotomized as at or above versus below the median and were controlled for in the logistic regression analysis. Covariates for patient satisfaction were Geriatric Depression Scale score, more than 1 limitation in activities or instrumental activities of daily living, primary diagnosis, a caregiver who was limited in at least 1 activity or instrumental activity of daily living, or a low MMSE score; covariates for family member satisfaction were patient living at the poverty level, primary diagnosis, having a child as a caregiver, or number of prescription medications being taken.

The change in scores for activities of daily living and instrumental activities of daily living was computed by taking the difference in scores between the baseline interview that assessed functional status 2 weeks before admission and the interview done 2 weeks after admission. Linear regression was used to control for covariates.

To compare costs, the mean amount paid by treatment method was combined across all 3 sites. We adjusted for inflation to September 2002 levels by using separate monthly consumer price index indicators for hospital and professional costs, including the costs of hospital-at-home staff. Because of the non-normal distribution, the statistical significance of differences in amount paid was tested by using nonparametric bootstrapping (1000 repetitions) with bias-corrected 95% CIs. Target accrual for the study was pragmatic.

All analyses were conducted using SAS, version 8.2 (SAS Institute, Inc., Cary, North Carolina), or Stata, version 8.0 (Stata Corp., College Station, Texas).

Role of the Funding Sources

The funding sources had no role in the design, conduct, or reporting of the study or in the decision to submit the manuscript for publication.

RESULTS

The **Figure** shows patient groups by study phase and by site. During the observation phase, there were 1251 patients in the target sample. Three hundred forty-nine (28%) were medically eligible for the study, of whom 286 (82%) consented to data collection; these made up the acute care hospital observation group. During the intervention phase of the study, there were 985 patients in the target sample, of whom 214 (22%) were medically eligible for the study. Of these patients, 141 were approached about receiving their care in hospital at home. Eighty-four received their care in this setting (overall, 60% of those approached—71% at site 1, 29% at site 2, and 68% at site 3), 57 patients declined hospital-at-home care, and 73 pa-

Table 1. **Treatment Status in Intervention Phase and Data Availability by Study Phase and Site**

Variable	Observation Phase			Intervention Phase							
	Total Eligible, *n*	Consented to Data Collection, *n* (%)*	Completed 2-Week Interviews, *n* (%)†	Total Eligible, *n*	Consented to Data Collection, *n* (%)*	Completed 2-Week Interviews, *n* (%)†	Treated in Hospital at Home, *n*	Declined Hospital-at-Home Treatment, *n*	Not Approached for Hospital-at-Home Treatment, *n*‡	Offered Hospital-at-Home Treatment, %§	Accepted Hospital-at-Home Treatment, %‖
Site 1	81	56 (69)	38 (47)	57	42 (74)	24 (42)	30	12	15	74	71
Site 2	158	135 (85)	75 (48)	71	47 (66)	28 (39)	10	24	37	48	29
Site 3	110	95 (86)	66 (60)	86	80 (93)	69 (80)	44	21	21	77	68
Total by phase	349	286 (82)	179 (51)	214	169 (79)	121 (57)	84	57	73	66	60

* Consented to at least medical record review and review of cost data.
† Consented to review of medical records and cost data; completed baseline interview; and completed 2-week follow-up interview.
‡ Not approached for hospital-at-home treatment because the patient required admission at times when hospital at home was not open for admissions (between 10:00 p.m. and 6:00 a.m.).
§ Defined as the number of participants treated in hospital at home + the number who declined hospital-at-home treatment/total number of intervention participants.
‖ Defined as the number of participants treated in hospital at home/number of participants offered hospital-at-home treatment.

Table 2. **Baseline Characteristics of Study Participants***

Variable	All Sites			Site 1		Site 2		Site 3	
	Observation Group (*n* = 286)	Intervention Group (*n* = 169)	*P* Value	Observation Group (*n* = 56)	Intervention Group (*n* = 42)	Observation Group (*n* = 135)	Intervention Group (*n* = 47)	Observation Group (*n* = 95)	Intervention Group (*n* = 80)
Mean age (SD), *y*	77.3 (6.6)	77.2 (7.0)	0.812	76.2 (7.1)	76.2 (7.0)	78.5 (6.7)	80.3 (6.4)	76.4 (5.8)	75.8 (6.8)
Gender (male), *% (n)*	66 (111)	58 (165)	0.092	41	36	40	40	93	96
Race (white), *% (n)*	90 (257)	86 (145)	0.192	80	79	96	87	86	89
Income (lives in poverty), *% (n)*†	11 (23)	19 (25)	0.027	15	11	7	9	13	27
Education (less than or equal to high school), *% (n)*†	34 (78)	36 (50)	0.651	33	41	40	39	25	33
Live alone, *% (n)*†	43 (122)	33 (55)	0.022	45	43	47	38	38	25
Any impairment in ADLs, *% (n)*†	44 (100)	45 (63)	0.821	37	57	38	31	56	46
Any impairment in IADLs, *% (n)*†	65 (149)	64 (90)	0.852	57	70	66	63	68	62
Mean MMSE (SD)‡	25.5 (4.2)	25.2 (4.4)	0.522	26.6 (3.6)	25.1 (5.9)	24.9 (3.9)	25.1 (3.9)	25.2 (4.7)	25.2 (3.9)
Code status DNR, *% (n)*	16 (47)	17 (28)	0.970						
Self-reported health (fair or poor), *% (n)*†	45 (102)	41 (57)	0.471	37	47	43	27	52	45
Mean of chronic medical conditions (SD), *n*	5.8 (2.7)	5.9 (2.5)	0.608	5.2 (3.1)	5.9 (3.0)	5.3 (2.3)	5.4 (2.4)	6.9 (2.7)	6.3 (2.2)
Mean Charlson comorbidity index (SD)§	3.1 (2.0)	3.0 (1.8)	0.849	2.7 (2.3)	2.7 (1.6)	2.6 (1.6)	2.5 (1.8)	3.9 (2.1)	3.5 (1.8)
Mean medications used as outpatient (SD), *n*	6.8 (3.9)	8.1 (4.5)	0.002	6.5 (4.3)	6.4 (3.7)	6.2 (3.2)	5.8 (3.0)	7.9 (4.4)¶	10.4 (4.6)
Mean APACHE II score (SD)‖	12.6 (2.9)	11.6 (3.4)	0.006	12.8 (4.3)	11.4 (3.7)	12.4 (3.7)	11.9 (3.6)	12.8 (3.9)¶	11.5 (3.1)
Primary admission diagnosis, *% (n)*									
Pneumonia	31 (89)	32 (54)	0.853	43¶	21	29¶	47	27	28
COPD	32 (92)	28 (48)	0.400	16¶	33	38	30	34	25
Cellulitis	12 (34)	18 (30)	0.082	16	19	13	9	7¶	23
CHF	25 (71)	22 (37)	0.478	25	26	20	15	32	24

* ADLs = activities of daily living; APACHE = Acute Physiology and Chronic Health Evaluation; CHF = chronic heart failure; COPD = chronic obstructive pulmonary disease; DNR = do not resuscitate; IADLs = instrumental activities of daily living; MMSE = Mini-Mental State Evaluation.
† Data from patient interview denominators vary as follows for the observation and intervention groups, respectively: income: 216, 131; education: 230, 138; lives alone: 278, 167; ADLs: 230, 141; IADLs: 230, 141; self-reported health: 229, 140.
‡ Higher score indicates higher level of cognitive function.
§ Higher score indicates increasing level of comorbid conditions.
‖ Higher score indicates increasing level of illness acuity.
¶ $P \leq 0.050$ comparing the observation phase with the intervention phase at the site.

tients were not approached to enroll in hospital-at-home during the intervention phase of the study because hospital at home was not open for admissions between 10:00 p.m. and 6:00 a.m. Treatment status in the intervention phase and data availability by study phase and site are described in **Table 1**. The consent and complete case rates probably reflect the relatively low incentive to participate in a study with a relatively high interview burden for patients in the observation group as a whole and for patients in the intervention group who were treated in the acute care hospital. Other operative factors may have included a more amenable research sample at the Veterans Administration medical center (site 3) and a higher proportion of African-American patients at site 1 who were less willing to participate in the research. Neither death nor active withdrawal from the study contributed to these rates. In addition, an analysis of characteristics of participants who completed all data collection through the 2-week follow-up interviews showed that they did not differ substantially from the characteristics of participants who declined any type of data collection at the site level or in the aggregate in each study phase.

Characteristics of the study samples are shown in **Table 2**. Overall, patients were elderly, white, and had a high burden of functional impairments and comorbid illnesses. Patients in the observation group and those in the intervention group were similar, but patients in the intervention phase were more likely to live in poverty, live alone, take more prescription medication on a daily basis as an outpatient, and have a lower illness acuity score. Aggregate differences among participants at sites 1, 2, and 3, respectively, were limited to age (76.2 years vs. 78.9 years vs. 76.1 years; $P < 0.001$), proportion of male participants (39% vs. 40% vs. 94%; $P < 0.001$), proportion of white participants (80% vs. 94% vs. 87%; $P = 0.002$), number of comorbid conditions (5.5 vs. 5.3 vs. 6.6; $P < 0.001$), and number of prescription medications used (6.4 vs. 6.1 vs. 9.0; $P < 0.001$). Within-site differences between the observation and intervention phases are described in **Table 2**.

Clinical care measures, including measures of hospital-

Table 3. **Comparison of Clinical Care Measures in Observation and Intervention Groups***

Variable	All Sites			Site 1		Site 2		Site 3	
	Observation Group (n = 286)	Intervention Group (n = 169)	P Value†	Observation Group (n = 56)	Intervention Group (n = 42)	Observation Group (n = 135)	Intervention Group (n = 147)	Observation Group (n = 95)	Intervention Group (n = 80)
Mean time between arrival home and hospital-at-home physician evaluation (range) [SD], *h*‡§	NA	1.8 (0–4.5) [1.0]	NA	NA	1.9 (0–4.2) [1.0]	NA	2.1 (1.3–3.5) [0.7]	NA	1.6 (0–4.5) [1.1]
Mean time to arrival of nurse at home, (range) [SD], *h*‡	NA	0.3 (0–3.3) [0.6]	NA	NA	0.3 (0–0.3) [0.7]	NA	0.3 (0–2.0) [0.7]	NA	0.3 (0–1.8) [0.4]
Mean time to arrival of oxygen at home (range) [SD], *h*‡	NA	2.2 (0–12) [3.6]	NA	NA	0.7 (0–2.3) [0.8]	NA	0.6 (0–1.4) [0.7]	NA	3.3 (0–12.0) [4.4]
Mean time to arrival of initial set of medications at home (range) [SD], *h*‡	NA	1.1 (0–4.8) [1.2]	NA	NA	0.8 (0–3.7) [1.1]	NA	0.6 (0–3.0) [1.1]	NA	1.3 (0–4.8) [1.3]
Mean continuous nursing (range) [SD], *h*‡‖	NA	16.9 (0–71) [14.6]	NA	NA	17.7 (0–71.0) [20.1]	NA	29.1 (18.0–50.0) [11.0]	NA	13.5 (3.0–43.0) [8.1]
Mean physician visits per day (range) [SD], *n*‡	NA	1.5 (0.8–2.0) [0.3]	NA	NA	1.4 (0.8–2.0) [0.4]	NA	1.1 (1.0–1.3) [0.3]	NA	1.6 (1.2–2.0) [0.3]
Mean intermittent nursing visits per day (range) [SD], *n*‡	NA	1.4 (0–5.3) [0.9]	NA	NA	1.6 (0–5.3) [1.3]	NA	1.2 (0–3.0) [0.9]	NA	1.3 (0–2.5) [0.6]
Mean time spent in emergency department (range) [SD], *h*	5.5 (1.0–21.3) [3.2]	6.4 (1.8–11.6) [1.9]	0.001	NA	6.4 (2.5–11.0) [2.0]	NA	6.5 (5.2–7.8) [1.1]	NA	6.4 (1.8–10.5) [1.9]
Admitted from emergency department, % *(n)*	91 (256)	91 (148)	0.995	85	90	96	89	87	92
Mean length of stay (SD), *d*	4.9 (9.9)	3.2 (2.5)	0.004	8.0 (20.8)	3.6 (2.7)	4.1 (4.3)	3.6 (2.6)	4.4 (3.8)**	2.7 (2.1)
Median length of stay (interquartile range), *d*¶	3.0 (2–5)	2.0 (2–4)	< 0.0001	4 (3–7)**	3 (2–4)	3 (2–5)	3 (2–5)	3 (2–5)**	2 (2–3)
Oxygen, % *(n)*	76 (217)	73 (123)	0.463	82	76	79	77	67	69
Intravenous antibiotics, % *(n)*	76 (217)	76 (128)	0.964	89¶	74	79	85	64	71
Nebulized bronchodilators, % *(n)*	49 (140)	49 (83)	0.974	48	50	61	58	33	44
Intravenous fluids, % *(n)*††	27 (76)	18 (31)	0.046	32**	5	23**	38	28**	14
Foley catheter, % *(n)*	23 (67)	14 (23)	0.011	16	12	30	23	19	9
Any difficult procedures, % *(n)*‡‡	65 (185)	32 (54)	< 0.001	54**	7	67	57	68**	30
Mean difficult procedures (SD), *n*	1.5 (1.8)	0.7 (1.2)	< 0.001	1.0 (1.5)**	0.1 (0.5)	1.5 (1.8)	1.3 (1.6)	2.0 (2.0)**	0.6 (1.1)
Mean consultation (SD), *n*	1.5 (1.5)	0.8 (1.3)	< 0.001	1.7 (1.6)**	0.3 (0.6)	1.3 (1.3)	1.4 (1.6)	1.8 (1.7)**	0.7 (1.2)
Any patient with ≥1 consultation, % *(n)*	70 (201)	36 (60)	< 0.001	70**	19	69	58	73**	31

* NA = not applicable.
† P value comparing observation versus intervention groups combined across sites.
‡ Applies only to the 84 patients in the intervention group who received hospital-at-home treatment.
§ Includes values of 0 for patients seen in the emergency department by a hospital-at-home physician.
‖ Includes values of 0 for patients who declined continuous nursing care.
¶ P value by Wilcoxon rank-sum, for median length of stay.
** $P \leq 0.050$ comparing the observation phase with the intervention phase at the site.
†† Excluding patients with a primary diagnosis of chronic heart failure.
‡‡ "Difficult" procedures to accomplish at home: continuous cardiac telemetry; radiologic studies, such as computed tomography, magnetic resonance imaging, echocardiography, or ultrasonography; exercise stress test; ventilation–perfusion scan; Holter monitor; endoscopic procedure; thoracentesis; paracentesis; blood product transfusion; and medications, such as intravenous heparin or intravenous nitroglycerin, that are difficult to administer in the home.

at-home feasibility, are shown in **Table 3**. Process outcomes for patients who received hospital-at-home care in the aggregate and at the site level show that this model was feasible: Nurses and physicians arrived promptly, and systems to deliver oxygen and medications functioned well and met standards established by the investigators. The mean and median lengths of stay for patients who received hospital-at-home care were substantially shorter than those for patients who were treated in the acute care hospital, with the shortest hospital-at-home length of stay at site 3. Care processes usually associated with hospital-level care, such as oxygen therapy, intravenous antibiotics, and nebulized bronchodilators, were used at similar rates. However, patients treated in the hospital at home were less likely to receive intravenous fluids, have a urinary catheter, have a "difficult" procedure performed, or have a consultation of any sort. At the site level, these differences were seen at sites 1 and 3 but not at site 2, where few patients received actual hospital-at-home care. At site 2, there were no statistically significant differences between the observation and intervention groups, except for the increased use of intravenous fluids in patients in the intervention group. This may have been related to the increased proportion of patients in the intervention group with community-acquired pneumonia who were treated at site 2. Illness-specific standards of care were met in similar proportions in both study groups at the aggregate and site levels (**Table 4**).

Complications experienced by patients in each of the

study groups are described in **Table 5**. The rate of incident delirium, including subsyndromal delirium, was 9% in the intervention group and 24% in the observation group. This difference remained significant in survival analyses (adjusted hazard ratio, 0.26 [95% CI, 0.12 to 0.57]). These results should be interpreted cautiously because data on delirium were not available for 42% of the sample. In addition, patients in the intervention group were less likely to have a sedative medication prescribed (adjusted odds ratio, 0.49 [CI, 0.30 to 0.81]). The small number of several outcomes precluded adjusted analyses. However, in the intervention group, there was a reduction in the use of chemical restraints, a trend toward reduction in the use of physical restraints, fewer critical complications, and a lower death rate. Again, at the site level, these differences were most apparent at sites 1 and 3. Two patients who initially received hospital-at-home care completed their treatment in the acute care hospital. One patient with chronic obstructive pulmonary disease had an episode of oxygen desaturation that did not respond initially to intensive bronchodilator treatment. Another patient with pneumonia insisted on using the bathroom alone, despite the presence of a nursing assistant. He fell and sustained a thoracic vertebral burst fracture, from which he recovered well.

Satisfaction of patients (median, 7 vs. 6 domains; $P < 0.001$) and family members (median, 6 vs. 5 domains; $P < 0.001$) was greater in the intervention group and remained statistically significant when controlled for covariates. In unadjusted and adjusted analyses, there were no differences in change in activities of daily living (0.04 vs. 0.09; $P = 0.711$) or in status of instrumental activities of daily living scores between the observation and intervention groups at 2 weeks (−0.07 vs. 0.14; $P = 0.280$). Given that satisfaction and functional outcomes were missing for 47% of participants, these results should be interpreted with caution because of the potential for bias.

The mean amounts paid for the index hospitalization for patients in the observation group and those in the intervention group were $7480 (SD, $8112) and $5081 (SD, $4427), respectively. Use of a nonparametric bootstrapping (31) approach to test for differences showed a difference in the amount paid for the index hospitalization at all 3 study sites (mean, $2398 [CI, $1376 to $3631]). The results from the bootstrapping approach did not differ from those of the parametric tests.

Eight weeks after admission, there were no differences in use of health services between the patients in the observation and intervention groups regarding mean number of emergency department visits (0.23 vs. 0.22; $P = 0.846$), mean number of inpatient hospital readmissions (0.28 vs. 0.27; $P = 0.892$), mean number of admissions to skilled nursing facilities (0.15 vs. 0.18; $P = 0.511$), or mean number of home health visits (1.80 vs. 1.78; $P = 0.971$).

Table 4. **Comparison of Illness-Specific Standards of Care in the Observation and Intervention Groups***

Variable	Observation Group ($n = 286$)	Intervention Group ($n = 169$)	Site 1		Site 2		Site 3	
			Observation Group	Intervention Group	Observation Group	Intervention Group	Observation Group	Intervention Group
Community-acquired pneumonia ($n = 143$), *n*	89	54	24	9	39	22	26	23
Antibiotics within 8 hours of admission, *% (n)*	96 (85)	93 (50)	100	89	97	91	89	96
Blood cultures obtained before administration of antibiotics, *% (n)*	61 (54)	52 (28)	63	56	56	36	65	65
Chronic heart failure ($n = 108$), *n*	71	37	14	11	27	7	30	19
Documentation of left ventricular function, *% (n)*	65 (46)	57 (21)	36	9	41	57	100	84
Use or consideration of use of angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker, *% (n)*	68 (48)	78 (29)	50	73	48	43	93	95
Use or consideration of use of β-blocker, *% (n)*	66 (47)	78 (29)	43	73	52	71	90	84
COPD ($n = 140$), *n*	92	48	9	14	51	14	32	20
Use of corticosteroids, *% (n)*	88 (81)	85 (41)	89	93	90	79	84	85
Use of nebulized bronchodilators, *% (n)*	82 (75)	85 (41)	89	100	90	79	66	80
Use of antibiotics, *% (n)*	72 (66)	79 (38)	67	86	78	93	63	65
Cellulitis ($n = 64$), *n*	34	30	9	8	18	4	7	18
Antibiotics within 8 hours of admission, *%(n)*	100 (34)	97 (29)	100	100	100	75	100	100
Blood cultures obtained before administration of antibiotics, *% (n)*	50 (17)	47 (14)	67	38	44	50	43	50

* The illness-specific standards of care examined were as follows: for community-acquired pneumonia, administration of antibiotics within 8 hours of admission and whether blood culture specimens were obtained before antibiotics were administered (28); for chronic heart failure, documentation of left ventricular function, use or consideration of use of angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker for patients with systolic dysfunction, and use or consideration of use of β-blocker (27); for COPD, use of corticosteroids, use of nebulized bronchodilators, and the use of antibiotics (26); for cellulitis, administration of antibiotics within 8 hours of admission and whether blood culture specimens were obtained before antibiotics were administered. COPD = chronic obstructive pulmonary disease.

Table 5. **Comparison of Clinical Complications Experienced by Participants in the Observation and Intervention Groups***

Variable	All Sites					Site 1		Site 2		Site 3	
	Observation Group (n = 286), n (%)	Intervention Group (n = 169), n (%)	Unadjusted Odds Ratio (95% CI)†	Adjusted Odds Ratio (95% CI)‡	P Value§	Observation Group (n = 56), %	Intervention Group (n = 42), %	Observation Group (n = 135), %	Intervention Group (n = 47), %	Observation Group (n = 95), %	Intervention Group (n = 80), %
Incident delirium (full and subsyndromal)‖	42 (24)	12 (9)	0.44 (0.23–0.83)	0.26 (0.12–0.57)¶		28**	8	18	18	18**	5
Sedative medication use	85 (30)	27 (16)	0.45 (0.28–0.73)	0.49 (0.30–0.81)		21	12	31	23	32**	14
Bowel complications	47 (16)	15 (9)	0.50 (0.27–0.92)	0.57 (0.30–1.07)		11	7	19	13	17**	8
Emergency situations (patients with ≥ 1)	31 (11)	10 (6)	0.52 (0.25–1.08)	0.62 (0.29–1.34)		16**	2	8	12	12	4
Chemical restraints	20 (7)	3 (2)			0.014	4	0	11	6	4	0
Urinary complications	18 (6)	5 (3)			0.128	4	5	11	4	1	1
Fall	6 (2)	2 (1)			0.72	4	2	2	0	2	1
Physical restraints	6 (2)	0 (0)			0.089	4	0	2	0	1	0
Nosocomial infection	6 (2)	1 (0.6)			0.267	2	0	3	2	1	0
Death	7 (3)	0 (0)			0.050	0	0	3	0	3	0
Critical complications (patients with ≥ 1)	16 (6)	0 (0)			<0.001	5	0	4	0	7**	0
Transfer from hospital at home to acute hospital	NA	2 (2)				NA	2	NA	2	NA	0

* NA = not applicable.
† Odds ratio for intervention effect.
‡ Odds ratio for intervention effect adjusted for age, gender, Acute Physiology and Chronic Health Evaluation II score, and site.
§ Fisher exact test probability reported.
‖ Denominators for delirium restricted to patients without prevalent delirium at the time of admission and to patients with >1 Confusion Assessment Method assessment. 173 patients in the observation group and 127 patients in the intervention group, hazard ratio reported.
¶ With additional specific delirium risk factors added as covariates: visual impairment, Mini-Mental State Examination <24, dehydration.
** $P \leq 0.050$ comparing the observation phase with the intervention phase at the site.

DISCUSSION

To our knowledge, this is the first study of a hospital-at-home model in the United States that substitutes entirely for acute hospital care. The data suggest that this model is feasible and efficacious. In 2 of 3 sites studied, 69% of acutely ill older persons who were medically eligible and who were offered hospital-at-home care opted for this type of treatment. Patients received timely hospital-level care at home that met quality standards. Compared with patients treated in the acute care hospital, those treated in the hospital at home had fewer important clinical complications, including use of sedative medications, use of chemical restraints, and incident delirium. Patient and family member satisfaction was higher in the hospital-at-home setting. In addition, the average amount paid for patients who received hospital-at-home care was lower than the amount paid for those who received care in the acute hospital setting.

In the literature, the definition of *hospital at home* is controversial (32). Most studies focus on outpatient intravenous infusion models and early hospital discharge schemes (5, 7). There have been fewer studies of substitutive hospital-at-home models in which patients avoid admission to an acute care hospital (5, 7–10, 13, 15). Compared with previous studies and models of substitutive hospital at home, our study is unique in several respects. First, our hospital-at-home model provided greater medical supervision than reported in previous studies. In most models, physician evaluation of patients in their homes is uncommon. For example, a recent systematic review of hospital-at-home care for patients with chronic obstructive pulmonary disease examined 7 studies, none of which provided substantial physician involvement (33). In the current model, the patients had at least daily physician visits at home. Studies suggest that physician involvement may be crucial in ensuring patient acceptance of hospital-at-home–type care in the United States (34, 35). In addition, patients had initial one-on-one nursing care for an extended period (mean, 16.9 hours), followed by at least daily home visits by a nurse, and 24-hour physician coverage for urgent clinical situations. Overall, substantial medical supervision was appropriate because of the nature of the patients and their illnesses and could not have been provided in a timely manner with standard community-based home care services. Second, the current model provided an intensive level of medical services not offered in many studies of hospital-at-home care. For example, 78% of patients who were treated at hospital at home received oxygen therapy, whereas previous studies would have excluded patients who required oxygen (13) and another study would have excluded patients who required intravenous therapy or full-time nursing care (9). Third, we reported on a wide range of outcomes, including clinical outcomes, satisfaction, function, and costs. Fourth, we demonstrated lower rates of complications, including incident delirium. An Australian study of patients who received hospital-at-home care reported a statistically significant decrease in delirium by reviewing medical records for evidence of "confusion" (13). In our study, the more rigorous assessment of the delirium outcome using the CAM probably better reflects the true rates of incident delirium and suggests that the care environment and process play a role in causing delirium (36). In addition, data for other clinical complications showed reduced odds ratios, although many were not statistically

significant in adjusted analyses. This may reflect a true lack of differences in these outcomes or a lack of power to detect such differences. Fifth, we examined process measures, use of hospital procedures and consultations, and standards of care to understand how the process of hospital-at-home care differs from acute hospital care and to demonstrate that the former type of care is less procedurally oriented while still maintaining appropriate care standards. Finally, our hospital-at-home model was implemented simultaneously in several types of health systems.

The study has important limitations. Patients were not randomly assigned to treatment, and differences between study groups may be attributable to selection bias. However, we used a highly conservative intention-to-treat analysis, which may have attenuated reported effects of the hospital at home, and adjusted clinical outcomes for differences in patient characteristics. In addition, although approximately 80% of participants consented to review of medical records and cost data, smaller proportions consented to interviews and contributed data to the analysis of outcomes, such as incident delirium, satisfaction, and function. This may have introduced additional bias into the results, although patients with complete and missing data were similar according to known characteristics.

The study experience at site 2 is instructive. The recruitment experience at site 2 differed from that of the other study sites, with a lower rate of patients treated in hospital at home and a higher rate of patients not approached for this type of treatment. There are several possible explanations for this, including the development of disease management programs launched in that health system during the study, a local nursing shortage that precluded that site's ability to coordinate the one-on-one nursing care required to start a hospital-at-home admission, and other unmeasurable organizational factors. We do not believe that the staff model–type arrangements at site 2 were a factor and, in fact, submit that such an integrated health care delivery system may be ideal for implementation of hospital-at-home care.

Temporal trends may have affected the study. This is reflected in the decline in the target sample between the 2 study phases, which may have been attributable to a mild influenza season during the intervention phase (37), the implementation of case management interventions at some study sites that may have effectively reduced the need for hospital admissions, or both. Because the hospital-at-home model we studied was limited to patients with 4 diagnoses and was done at several Medicare + Choice plans and a Veterans Administration medical center, the results may not be generalizable to the treatment of patients with other illnesses, other samples of older persons, or other health systems.

Despite these limitations and the need for continued rigorous research in this area, our study shows that an innovative substitutive hospital-at-home model for selected older patients with common acute medical conditions is feasible and efficacious in selected health care systems. As the U.S. population ages and the burden of chronic disease and demand for acute hospital services increase, we believe that hospital at home, as a hospital-based unit, can play an important role in the health care system of the future.

From Johns Hopkins University School of Medicine, Johns Hopkins Bayview Medical Center, and The Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; Portland Veterans Administration Medical Center and Oregon Health & Science University, Portland, Oregon; State University of New York, Independent Health, and Univera Health, Buffalo, New York; Fallon Community Health Plan and Fallon Clinic, Worcester, Massachusetts; Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts; and The John A. Hartford Foundation, New York, New York.

Note: Portions of this work have been presented at meetings of the American Geriatrics Society, May 2001, 2003, 2004; the Gerontological Society of America, November 2002, November 2003; and the American Academy of Home Care Physicians, May 2005.

Acknowledgments: The authors thank the following people without whom the study would not have been possible: Nurse Study Coordinators: Maggie Donius, Susan Saltzman, Christine Delano; Delirium Data Coordinators and other site personnel: Kristine Noonan, Lana McBride, Kathleen Chapman, Richard Harper, Wendy Wanlass, Carol Joseph, Nora Tobin, Jim Jackson, Joyce Holohan-Bell, Kay Schecter, Carol Baird, Sandie Taylor, Cleo Scribner, Kay Jenkins, Candace LaBlanc, Marcia Kirkpatrick, Diane Davies; Annette Hopkins for Confusion Assessment Method training and data review; Coordinating Center Data Safety Monitoring Board members: Anne Perkins, Knight Steel, George Taler, Stephanie Wilmer; Becky Clark for data management; Charles Rohde for advice on statistical methods; Curtis Meinert for advice on study design; Leslie Odendhal for coordinating center activities and manuscript preparation; Donna Regenstreif for her initial vision of the hospital at home; The John A. Hartford Foundation of New York for their ongoing support; Ronald Peterson for his support of hospital-at-home development at Johns Hopkins; and the patients, family members, and caregivers who participated in the study.

Grant Support: By a grant from the John A. Hartford Foundation of New York, grant no. 98309-G, and supplemented by the Portland Oregon Veterans Administration Medical Center by a Department of Veterans Affairs New Clinical Initiative Program grant no. 99-027. Dr. Inouye was supported, in part, by grant no. K24AG00949 from the National Institute on Aging.

Potential Financial Conflicts of Interest: None disclosed.

Requests for Single Reprints: Bruce Leff, MD, John Hopkins Bayview Medical Center, The Johns Hopkins Care Center, John R. Burton Pavilion, 5505 Hopkins Bayview Circle, Baltimore, MD 21224; e-mail, bleff@jhmi.edu; Web site, www.hospitalathome.org.

Current author addresses and author contributions are available at www.annals.org.

References

1. **Covinsky KE, Palmer RM, Fortinsky RH, Counsell SR, Stewart AL, Kresevic D, et al.** Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age. J Am Geriatr

Soc. 2003;51:451-8. [PMID: 12657063]
2. **Inouye SK, Bogardus ST Jr, Charpentier PA, Leo-Summers L, Acampora D, Holford TR, et al.** A multicomponent intervention to prevent delirium in hospitalized older patients. N Engl J Med. 1999;340:669-76. [PMID: 10053175]
3. **Creditor MC.** Hazards of hospitalization of the elderly. Ann Intern Med. 1993;118:219-23. [PMID: 8417639]
4. **Leff B, Burton JR.** Acute medical care in the home [Editorial]. J Am Geriatr Soc. 1996;44:603-5. [PMID: 8617915]
5. **Montalto M.** Hospital in the Home: Principles and Practice. Melbourne: ArtWords Publishing; 2002.
6. **Leff B.** Acute? care at home. The health and cost effects of substituting home care for inpatient acute care: a review of the evidence. J Am Geriatr Soc. 2001; 49:1123-5. [PMID: 11555078]
7. **Shepperd S, Iliffe S.** Hospital at home versus in-patient hospital care. Cochrane Database Syst Rev. 2005(3):CD000356. [PMID: 16034853]
8. **Ricauda NA, Bo M, Molaschi M, Massaia M, Salerno D, Amati D, et al.** Home hospitalization service for acute uncomplicated first ischemic stroke in elderly patients: a randomized trial. J Am Geriatr Soc. 2004;52:278-83. [PMID: 14728641]
9. **Davies L, Wilkinson M, Bonner S, Calverley PM, Angus RM.** "Hospital at home" versus hospital care in patients with exacerbations of chronic obstructive pulmonary disease: prospective randomised controlled trial. BMJ. 2000;321: 1265-8. [PMID: 11082090]
10. **Wilson A, Parker H, Wynn A, Jagger C, Spiers N, Jones J, et al.** Randomised controlled trial of effectiveness of Leicester hospital at home scheme compared with hospital care. BMJ. 1999;319:1542-6. [PMID: 10591717]
11. **Shepperd S, Harwood D, Jenkinson C, Gray A, Vessey M, Morgan P.** Randomised controlled trial comparing hospital at home care with inpatient hospital care. I: three month follow up of health outcomes. BMJ. 1998;316: 1786-91. [PMID: 9624068]
12. **Stessman J, Ginsberg G, Hammerman-Rozenberg R, Friedman R, Ronen D, Israeli A, et al.** Decreased hospital utilization by older adults attributable to a home hospitalization program. J Am Geriatr Soc. 1996;44:591-8. [PMID: 8617912]
13. **Caplan GA, Ward JA, Brennan NJ, Coconis J, Board N, Brown A.** Hospital in the home: a randomised controlled trial. Med J Aust. 1999;170:156-60. [PMID: 10078179]
14. **Montalto M, Dunt D.** Home and hospital intravenous therapy for two acute infections: an early study. Aust N Z J Med. 1997;27:19-23. [PMID: 9079248]
15. **Leff B, Burton L, Guido S, Greenough WB, Steinwachs D, Burton JR.** Home hospital program: a pilot study. J Am Geriatr Soc. 1999;47:697-702. [PMID: 10366169]
16. **Leff B, Burton L, Bynum JW, Harper M, Greenough WB, Steinwachs D, et al.** Prospective evaluation of clinical criteria to select older persons with acute medical illness for care in a hypothetical home hospital. J Am Geriatr Soc. 1997; 45:1066-73. [PMID: 9288013]
17. **Knaus WA, Draper EA, Wagner DP, Zimmerman JE.** APACHE II: a severity of disease classification system. Crit Care Med. 1985;13:818-29. [PMID: 3928249]
18. **Charlson ME, Pompei P, Ales KL, MacKenzie CR.** A new method of classifying prognostic comorbidity in longitudinal studies: development and validation. J Chronic Dis. 1987;40:373-83. [PMID: 3558716]
19. **Bach PB, Brown C, Gelfand SE, McCrory DC.** Management of acute exacerbations of chronic obstructive pulmonary disease: a summary and appraisal of published evidence. Ann Intern Med. 2001;134:600-20. [PMID: 11281745]
20. **Hunt SA, Baker DW, Chin MH, Cinquegrani MP, Feldman AM, Francis GS, et al.** ACC/AHA guidelines for the evaluation and management of chronic heart failure in the adult: executive summary. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to revise the 1995 Guidelines for the Evaluation and Management of Heart Failure). J Am Coll Cardiol. 2001;38:2101-13. [PMID: 11738322].
21. **Niederman MS, Mandell LA, Anzueto A, Bass JB, Broughton WA, Campbell GD, et al.** Guidelines for the management of adults with community-acquired pneumonia. Diagnosis, assessment of severity, antimicrobial therapy, and prevention. Am J Respir Crit Care Med. 2001;163:1730-54. [PMID: 11401897]
22. **Katz S, Ford AB, Moskowitz RW, Jackson BA, Jaffe MW.** Studies of illness in the aged. The index of ADL: a standardized measure of biological and psychosocial function. JAMA. 1963;185:914-9. [PMID: 14044222]
23. **Lawton MP, Brody EM.** Assessment of older people: self-maintaining and instrumental activities of daily living. Gerontologist. 1969;9:179-86. [PMID: 5349366].
24. **Yesavage JA, Brink TL, Rose TL, Lum O, Huang V, Adey M, et al.** Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res. 1982;17:37-49. [PMID: 7183759]
25. **Folstein MF, Folstein SE, McHugh PR.** "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res. 1975;12:189-98. [PMID: 1202204]
26. **Cummings J.** Clinical Neuropsychiatry. Vol. 9. Orlando: Grune & Stratton; 1985.
27. **Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI.** Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann Intern Med. 1990;113:941-8. [PMID: 2240918]
28. **Uhlmann RF, Larson EB, Buchner DM.** Correlations of Mini-Mental State and modified Dementia Rating Scale to measures of transitional health status in dementia. J Gerontol. 1987;42:33-6. [PMID: 3794193]
29. **Cole M, McCusker J, Dendukuri N, Han L.** The prognostic significance of subsyndromal delirium in elderly medical inpatients. J Am Geriatr Soc. 2003;51: 754-60. [PMID: 12757560]
30. **Picker Institute Hospital.** Picker Institute Hospital Satisfaction Questionnaire. Boston, MA: Picker Institute Hospital; 1996.
31. **Barber JA, Thompson SG.** Analysis of cost data in randomized trials: an application of the non-parametric bootstrap. Stat Med. 2000;19:3219-36. [PMID: 11113956]
32. **Leff B, Montalto M.** Home hospital—toward a tighter definition [Letter]. J Am Geriatr Soc. 2004;52:2141. [PMID: 15571559]
33. **Ram FS, Wedzicha JA, Wright J, Greenstone M.** Hospital at home for patients with acute exacerbations of chronic obstructive pulmonary disease: systematic review of evidence. BMJ. 2004;329:315. [PMID: 15242868].
34. **Fried TR, van Doorn C, O'Leary JR, Tinetti ME, Drickamer MA.** Older persons' perceptions of home and hospital as sites of treatment for acute illness. Am J Med. 1999;107:317-23. [PMID: 10527032]
35. **Fried TR, van Doorn C, O'Leary JR, Tinetti ME, Drickamer MA.** Older persons' preferences for home vs hospital care in the treatment of acute illness. Arch Intern Med. 2000;160:1501-6. [PMID: 10826465]
36. **Inouye SK, Leo-Summers L, Zhang Y, Bogardus ST Jr, Leslie DL, Agostini JV.** A chart-based method for identification of delirium: validation compared with interviewer ratings using the confusion assessment method. J Am Geriatr Soc. 2005;53:312-8. [PMID: 15673358]
37. **Bridges CB, Harper SA, Fukuda K, Uyeki TM, Cox NJ, Singleton JA, et al.** Prevention and control of influenza. Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep. 2003;52:1-34; quiz CE1-4. [PMID: 12755288]

Current Author Addresses: Drs. Leff, Greenough, and Burton and Ms. Guido: Johns Hopkins Bayview Medical Center, The Johns Hopkins Care Center, John R. Burton Pavilion, 5505 Hopkins Bayview Circle, Baltimore, MD 21224.

Drs. Burton, Frick, and Steinwachs: Johns Hopkins University Bloomberg School of Public Health, Hampton House, 624 North Broadway, Baltimore, MD 21205.

Dr. Mader: P.O. Box 1035 (V-9-DIR), Portland Veterans Administration Medical Center, Portland, OR 97207.

Dr. Naughton: State University of New York, Buffalo, 100 High Street, Buffalo, NY 14203.

Dr. Burl: Fallon Clinic, 10 Chestnut Street, Worcester, MA 01609.

Dr. Inouye: Aging Brain Center, Institute for Aging Research, Hebrew Senior Life, 1200 Centre Street, Boston, MA 02131.

Dr. Langston: 125 Park Avenue, New York, NY 10017.

Impact of Complex Care Management on Spending and Utilization for High-Need, High-Cost Medicaid Patients

Brian W. Powers, MD, MBA; Farhad Modarai, DO; Sandeep Palakodeti, MD, MPH; Manisha Sharma, MD; Nupur Mehta, MD; Sachin H. Jain, MD, MBA; and Vivek Garg, MD, MBA

ABSTRACT

OBJECTIVES: Complex care management programs have emerged as a promising model to better care for high-need, high-cost patients. Despite their widespread use, relatively little is known about the impact of these programs in Medicaid populations. This study evaluated the impact of a complex care management program on spending and utilization for high-need, high-cost Medicaid patients.

STUDY DESIGN: Randomized quality improvement trial conducted at CareMore Health in Memphis, Tennessee. A total of 253 high-need, high-cost Medicaid patients were randomized in a 1:2 ratio to complex care management or usual care.

METHODS: Intention-to-treat analysis compared regression-adjusted rates of spending and utilization between patients randomized to the complex care program (n = 71) and those randomized to usual care (n = 127) over the 12 months following randomization. Primary outcomes included total medical expenditures (TME) and inpatient (IP) days. Secondary outcomes included IP admission, emergency department (ED) visits, care center visits, and specialist visits.

RESULTS: Compared with patients randomized to usual care, patients randomized to complex care management had lower TME (adjusted difference, –$7732 per member per year [PMPY]; 95% CI, –$14,914 to –$550; *P* = .036), fewer IP bed days (adjusted difference, –3.46 PMPY; 95% CI, –4.03 to –2.89; *P* <.001), fewer IP admissions (adjusted difference, –0.32 PMPY; 95% CI, –0.54 to –0.11; *P* = .014), and fewer specialist visits (adjusted difference, –1.35 PMPY; 95% CI, –1.98 to –0.73; *P* <.001). There was no significant impact on care center or ED visits.

CONCLUSIONS: Carefully designed and targeted complex care management programs may be an effective approach to caring for high-need, high-cost Medicaid patients.

Am J Manag Care. 2020;26(2):e57-e63

High-need, high-cost patients—those with chronic medical conditions and co-occurring social and behavioral complexity—experience poor health outcomes and high rates of potentially preventable spending.[1-8] Improving care quality and lowering spending for this population have become a focus for policy makers, clinicians, payers, and health systems.[3,4,8]

Complex care management programs—broadly defined as efforts to coordinate medical and social services, assist patients and caregivers in managing medical and behavioral health conditions, and address the psychosocial drivers of poor health—have emerged as a promising model to improve care for high-need, high-cost patients.[8-13] In recent years, complex care management programs have been widely adopted by health systems and delivery organizations entering into value-based payment arrangements. A 2018 survey found that 96% of accountable care organizations had implemented complex care management programs for high-need, high-cost patients.[14]

AJMC
Copyright © Managed Care & Healthcare Communications, LLC

The impact of complex care management has been uneven. Systematic reviews and large-scale program evaluations have not demonstrated a consistent impact on health outcomes, spending, or acute care utilization.[15-17] Some individual programs, however, have led to improvements in patient-reported health and decreases in acute care utilization and total spending.[11,15,16,18,19] Program heterogeneity (eg, practice setting, patient characteristics, care models, staffing) may explain these varied results.

Complex care management programs have traditionally been developed and implemented among Medicare populations.[11,12,15,16,20] Increasingly, these models are being adopted in Medicaid.[14,21-24] Similar to the Medicare population, high-need, high-cost Medicaid patients have high rates of chronic conditions[25] and preventable acute care utilization,[6,26,27] both attributes well suited to complex care management.[13] High-need, high-cost Medicaid patients also have high rates of behavioral health disorders and unmet social needs,[6,21,28,29] attributes less common among Medicare patients and areas in which the impact of complex care management is uncertain.

Despite the proliferation of complex care management for Medicaid patients, there have been very few rigorous program

TAKEAWAY POINTS

A complex care management program for high-need, high-cost Medicaid patients reduced total medical expenditures by 37% and inpatient utilization by 59%. Based on the design of the program, these results suggest that:

- Carefully designed and targeted complex care management can be effective among high-need, high-cost Medicaid patients.
- Community health workers and other nontraditional healthcare workers can help engage and activate patients, build trust, and better understand and manage the nonmedical drivers of poor health and avoidable spending.
- Targeted interventions focused on modifiable risk factors are an effective and efficient approach for reducing unnecessary utilization.

evaluations, and the overall effect of these programs is unclear. This paper presents the results of a randomized quality improvement trial to evaluate the impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients with complex health and social needs.

METHODS

Design and Setting

This was a randomized quality improvement trial to evaluate the impact of a complex care management program on spending and utilization for high-need, high-cost Medicaid patients. The design and implementation of the program, detailed in the following paragraphs, incorporated attributes of successful complex care management programs in other populations.[8,11,13,20,30] The program was implemented at CareMore Health (CareMore) in Memphis, Tennessee, where CareMore provides comprehensive primary care services for Medicaid patients enrolled in TennCare plans administered by Amerigroup. The program was operated out of a single CareMore care center.

Population

Participants were drawn from adult Medicaid patients attributed to CareMore primary care physicians (PCPs). Program eligibility criteria were aimed at identifying patients at risk for poor outcomes and unnecessary spending, as well as those most likely to benefit from complex care management. The criteria drew from analyses suggesting that combining predictive models, historical claims, and clinician judgment is the most effective approach to identifying patients for complex care management.[13,31-34]

Eligible patients were first required to meet at least 1 of the following criteria: top 5% of total medical expenditures (TME) in the prior 12 months, top 5% of Chronic Illness Intensity Index (CI3) score, or care team member nomination. The CI3 score is a predictive model developed by Amerigroup that uses demographic, clinical, and pharmacy claims data to estimate a patient's predicted cost in the subsequent 12 months compared with the average Amerigroup Medicaid patient.

Patients meeting 1 of the above criteria were then required to meet at least 1 of the following criteria: 2 or more inpatient (IP) admissions in the prior 12 months, 3 or more emergency department (ED) visits in the prior 12 months, or 2 or more chronic conditions.

Patients less likely to benefit from complex care management because of specific comorbidities (cognitive impairment, severe mental illness without medical comorbidity, active malignancy, pregnancy) or current residence in a long-term care facility were excluded.

Given limited resources, eligible patients were randomized in a 1:2 ratio to complex care management or usual care. Patients not continuously attributed to CareMore over the 12-month period following randomization were considered lost to follow-up. This could occur for several reasons: loss of Medicaid eligibility, enrollment in another TennCare plan, or transfer of care to a non-CareMore PCP.

Program Description

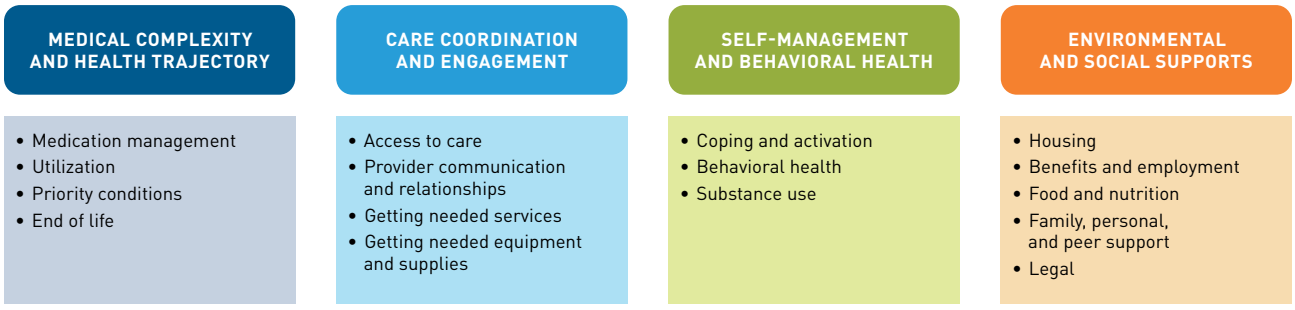
The program was staffed by a multidisciplinary care team consisting of a community health worker (CHW), a social worker (SW), and a PCP. CHWs and other nontraditional healthcare workers have become increasingly common components of complex care management programs.[35] CHWs, drawn from local communities, build longitudinal relationships with patients, provide context-specific activation and engagement, assist with care coordination, and help patients navigate the complexities of health systems and social programs.[35] CHW interventions have been shown to improve health outcomes and reduce spending, especially among urban, underserved populations.[22,36-41]

With guidance and support from the SW and the PCP, the CHW was responsible for patient outreach, engagement, activation, and accompaniment. The SW was responsible for counseling and brief interventions for patients with behavioral health needs and for coordinating referrals to social service agencies and other medical providers. The PCP was responsible for providing comprehensive care for acute and chronic conditions and for coordinating with specialists and inpatient providers.

Patients randomized to the complex care management program were contacted by the CHW via telephone and invited to enroll in the program. The CHW attempted to contact patients on 3 separate occasions, after which no additional attempts at contact were made.

Program activities were designed around a conceptual model of the drivers of poor outcomes and avoidable spending for high-need, high-cost Medicaid patients. Drawing on existing frameworks,[42] these drivers were grouped into 4 intersectional domains: (1) medical complexity and health trajectory, (2) care coordination and engagement, (3) self-management and behavioral health, and (4) environmental and social supports. Within each domain, specific drivers of poor health and high costs were identified. For example, unstable housing was a driver within the environmental and social supports domain, and medication management was a driver within

FIGURE 1. Conceptual Model of the Domains and Drivers of Poor Outcomes and Avoidable Spending for High-Need, High-Cost Medicaid Patients



the medical complexity and health trajectory domain (see **Figure 1** for a complete list of domains and drivers).

Patients who enrolled in the program were scheduled for a 60-minute in-person intake visit within 7 days of enrollment. During the intake visit, the entire care team (ie, CHW, SW, and PCP) conducted a comprehensive assessment of the patient's medical, behavioral, and social risk factors. The results of this assessment were used to identify and prioritize the most impactful and impactable drivers of poor outcomes and avoidable spending for each patient. Finally, the patient and the care team codeveloped a tailored care plan that outlined interventions, roles, and responsibilities for addressing each of the prioritized drivers. For example, the SW may be responsible for providing counseling and brief interventions for depression and for coordinating referrals to psychiatry. The PCP may be responsible for rapidly addressing poorly controlled diabetes or congestive heart failure. The CHW may be responsible for contacting patients to identify barriers to adherence and self-management. The patient may be responsible for applying for temporary housing assistance, logging physical activity, or checking in daily with the CHW/PCP to provide blood pressure or blood sugar readings.

After the intake visit, there was frequent, structured follow-up. The CHW called patients at least weekly to assess progress and identify and troubleshoot barriers. The care team met formally every week to review and update care plans. Patients were scheduled for monthly, in-person follow-up visits to review and revise the care plan. Patients admitted to an IP or skilled nursing facility were visited by a member of the care team, if possible. The CHW accompanied patients to specialist, social service, and other appointments as needed.

The program launched on March 1, 2017, and ran until February 28, 2018, at which point patients returned to usual care.

Data Sources and Measures

The primary outcomes were TME and IP bed days. Secondary outcomes included ED visits, IP admissions, care center visits, and specialist visits. The ED visit outcome measure excluded visits that resulted in an IP admission. The care center visit measure included any in-person visit for medical or behavioral health services at one of CareMore's outpatient facilities. All outcomes were assessed over the 12-month period following randomization (March 1, 2017, to February 28, 2018).

The following covariates were assessed for each patient: age at randomization, gender, CI3 score at randomization, and rates of each outcome measure over the 12 months prior to randomization (March 1, 2016, to February 28, 2017). Spending and utilization rates were calculated from claims data provided by Amerigroup. CI3 scores were provided by Amerigroup. Demographic data were extracted from the CareMore electronic data warehouse.

Statistical Analysis

Baseline characteristics for patients randomized to complex care management and those randomized to usual care were compared using standardized mean differences (SMDs).[43] Proposed cutoffs vary, but SMDs greater than 0.1 or 0.25 are generally considered to represent an important difference between groups.[44,45]

The effect of the program on the primary and secondary outcomes was analyzed through an intention-to-treat approach based on random assignment. Count-based utilization outcomes (IP admissions, IP bed days, ED visits, care center visits, and specialist visits) were modeled with Poisson regression, and the spending outcome (TME) was modeled with ordinary least squares regression. Both adjusted and unadjusted analyses were performed. Adjusted models included age at randomization, gender, CI3 score at randomization, and the corresponding outcome measure over the 12-month period prior to randomization (eg, the model for IP days included IP days from March 1, 2016, to February 28, 2017, as a covariate). Adjusted and unadjusted results were similar. Results from the adjusted models are presented below, with unadjusted results available in the **eAppendix** (available at **ajmc.com**). A *P* value of .05 was considered to indicate statistical significance. *P* values were adjusted for multiple comparison using the Holm-Bonferroni method.[46] All analyses were performed using R version 3.5.1. The evaluation was implemented as a randomized quality improvement trial without institutional review board approval or waiver.

FIGURE 2. Flow of Patients Through the Trial

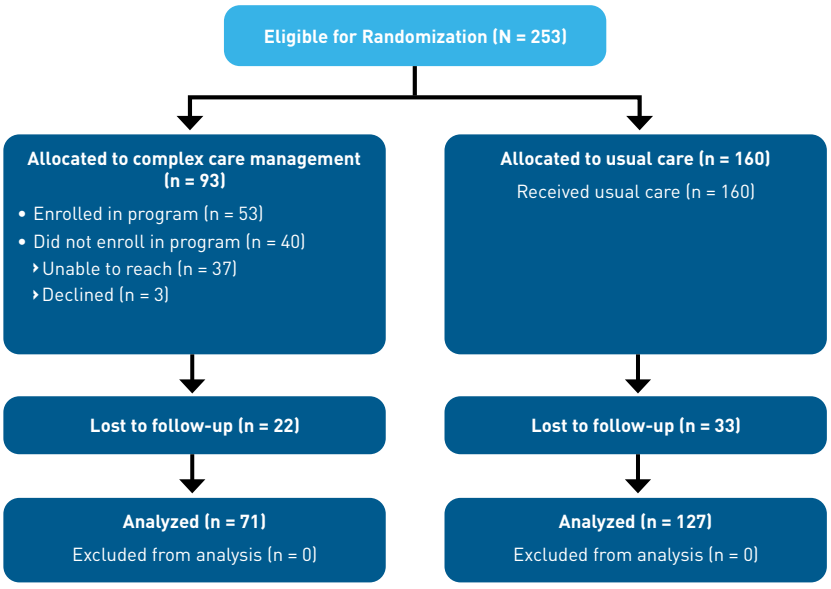


TABLE 1. Baseline Characteristics for Patients by Study Group[44,45,a]

	Complex Care Management (n = 71)	Usual Care (n = 127)	SMD[b]
Age in years,[c] mean (SD)	43.8 (15.6)	45.9 (14.5)	−0.139
Sex, % male	43.7	42.5	0.023
CI3 score,[d] mean (SD)	8.56 (6.87)	9.99 (8.46)	−0.180
TME in prior 12 months ($), mean (SD)	21,429 (33,859)	23,432 (29,723)	−0.064
IP admissions in prior 12 months, mean (SD)	1.28 (2.64)	1.17 (2.25)	0.045
IP days in prior 12 months, mean (SD)	6.90 (15.80)	6.77 (13.67)	0.009
ED visits in prior 12 months, mean (SD)	3.82 (6.62)	3.01 (4.70)	0.148
Care center visits in prior 12 months, mean (SD)	4.14 (6.22)	4.07 (5.12)	0.013
Specialist visits in prior 12 months, mean (SD)	5.55 (6.61)	6.38 (9.18)	−0.099

CI3 indicates Chronic Illness Intensity Index; ED, emergency department; IP, inpatient; SMD, standardized mean difference; TME, total medical expenditures.

[a]Baseline spending and utilization rates were calculated over the 12-month period prior to randomization (March 1, 2016, to February 28, 2017).

[b]SMD is calculated by taking the mean of each group, divided by the standard deviation of the entire population.[44] Proposed cutoffs vary, but SMDs greater than 0.1 or 0.25 are generally considered to represent an important difference between groups.[44,45]

[c]Age at randomization.

[d]CI3 is a predictive score that estimates a patient's relative predicted cost in the subsequent 12 months compared with the average patient. See Methods for more details.

RESULTS

Randomization, Enrollment, and Follow-up

Figure 2 depicts the flow of patients through the trial. A total of 253 patients met eligibility criteria and were randomized in a 1:2 ratio to complex care management (n = 93) or usual care (n = 160). More than half (56.9%) of the patients randomized to complex care management ultimately enrolled in the program. The most common reason for not enrolling was an inability for the CHW to reach the patient via telephone (37 of 40 patients). A small number of patients were reached but declined to participate in the program (3 of 40 patients). Across both groups, roughly 20% of patients were lost to follow-up in the 12 months after randomization. The intention-to-treat analysis included 71 patients in the complex care management group and 127 patients in the usual care group. Information on appointment-kept rates is provided in the eAppendix.

Baseline Characteristics

Baseline rates of spending and utilization were high. The average patient incurred TME of $22,714, spent 6.81 days in an IP facility, and visited the ED 3.30 times during the 12-month period prior to randomization. Table 1[44,45] compares baseline characteristics between patients randomized to complex care management and those randomized to usual care. Compared with patients in the usual care group, patients in the complex care management group were slightly younger (mean age of 43.8 vs 45.9 years), had lower predicted future costs (mean CI3 score of 8.56 vs 9.99), and visited the ED more frequently (3.82 vs 3.01 mean visits).

Spending and Utilization Outcomes

Table 2 compares adjusted rates of utilization and spending between patients randomized to complex care management and those randomized to usual care over the 12 months following randomization. The complex care management program was associated with lower TME (adjusted difference, −$7732 per member per year [PMPY]; 95% CI, −$14,914 to −$550; $P = .036$), fewer IP bed days (adjusted difference, −3.46 PMPY; 95% CI, −4.03 to −2.89; $P < .001$), fewer IP admissions (adjusted difference, −0.32 PMPY; 95% CI, −0.54 to −0.11; $P = .014$), and fewer specialist visits (adjusted difference, −1.35 PMPY; 95% CI, −1.98 to 0.73; $P < .001$). There was no significant impact on ED or care center visits.

Patient Vignettes

The eAppendix includes summary vignettes for selected patients enrolled in complex care management. These are intended to

supplement the quantitative findings from the primary analysis and offer additional detail on the implementation of complex care planning.

DISCUSSION

A complex care management program reduced spending and inpatient utilization among high-need, high-cost Medicaid patients. Patients randomized to complex care management had TME that were 37% lower than those randomized to usual care, an absolute reduction of $7732 per patient per year. This spending reduction appeared to be driven primarily by decreases in inpatient utilization—bed days were reduced by 59% and admissions by 44%.

Several potential mechanisms could explain the observed decreases in utilization and spending. Improved management of medical, social, and behavioral risk factors may have prevented acute exacerbations of chronic disease. Patient engagement and activation may have led to improved self-management and adherence. Finally, social and behavioral stabilization may have facilitated safe discharge planning, reducing the need for, or duration of, inpatient admissions.

TABLE 2. Adjusted Rates of Spending and Utilization for Patients Randomly Assigned to Complex Care Management Versus Usual Care[a]

	Complex Care Management	Usual Care	Difference (95% CI)	P[b]
Primary outcomes				
TME ($/patient/year)	13,091	20,823	−7732 (−14,914 to −550)	.036
IP days (patient/year)	2.41	5.87	−3.46 (−4.04 to −2.89)	<.001
Secondary outcomes				
IP admissions (patient/year)	0.41	0.73	−0.32 (−0.54 to −0.11)	.014
ED visits (patient/year)	2.77	2.79	−0.02 (−0.51 to 0.47)	1.00
Care center visits (patient/year)	4.80	4.33	0.47 (−0.16 to 1.11)	.576
Specialist visits (patient/year)	4.08	5.43	−1.35 (−1.98 to −0.73)	<.001

ED indicates emergency department; IP, inpatient; TME, total medical expenditures.

[a]Spending and utilization rates are adjusted for age at randomization, gender, Chronic Illness Intensity Index score at randomization, and the corresponding outcome measure over the 12-month period prior to randomization (eg, IP days are adjusted for IP days from March 1, 2016, to February 28, 2017).

[b]Adjusted for multiple comparisons (Holm-Bonferroni).

Complex care management led to a small but significant decrease in specialist visits. Although prior studies of complex care management have not examined specialist use, data from primary care improvement initiatives suggest that enhanced primary care services can reduce downstream specialist utilization.[47,48] In this study, specialist utilization could have been decreased by increased engagement with primary care, better management of chronic medical conditions in the primary care setting, or better communication and coordination between the PCP and specialists. Because there were no additional financial or nonfinancial incentives to reduce utilization in the complex care management group, it is less likely that the reduction in specialist utilization was due to restricted access.

Complex care management had no impact on ED utilization. This contrasts with findings from some programs targeting Medicare patients[18,19] and may be explained by a differential approach to ED utilization between Medicare and Medicaid patients. Research suggests that even with access to primary care, Medicaid patients use the ED at high rates.[49,50] Additional research is needed to better understand the drivers of ED utilization among high-need, high-cost Medicaid patients.

Despite a focus on structured engagement and follow-up, patients randomized to complex care management did not visit CareMore care centers more frequently than patients randomized to usual care. This suggests that the character of outpatient visits (eg, social and behavioral risk assessments, structured care planning, patient engagement and activation) may be more important than the quantity of those visits. It is also possible that telephonic or virtual contact with care team members, which occurred frequently for patients enrolled in the complex care program, can be an effective substitute for in-person visits among engaged patients.

Taken together, the results of this study have several important implications for the design and implementation of complex care management programs for high-need, high-cost patients.

First, these findings add to an emerging evidence base suggesting that carefully designed and targeted care management programs can reduce spending and utilization in Medicaid populations.[22,36,38] The magnitude of utilization and spending reductions observed in this study were similar to those reported in recent evaluations of complex care management and CHW programs for Medicaid populations[22,36,38] and substantially larger than those reported from programs targeting Medicare patients.[15,16,18,19] Although additional evaluations of programs targeting both populations are needed, these findings suggest that high-need, high-cost Medicaid patients may be better suited for complex care management.

Second, patterns of utilization in the 2 study groups underscore the importance of precise patient targeting. To be most effective, complex care management programs should target patients at risk of persistently high spending and those whose spending and health outcomes are amenable to complex care planning and engagement. Many complex care management programs use claims data and historical utilization patterns to identify eligible patients. Recent research has highlighted the limitations of this approach—historically high-cost patients often return to normal patterns or spending, or they have drivers of high spending not amenable to complex care management.[34,51,52] The eligibility criteria in this study made use

of a hybrid strategy that integrated historical claims data, predictive models, and clinician judgment. The persistently high rates of utilization observed in the usual care group and the decrease in utilization observed in the complex care management group suggest that these criteria successfully identified patients at risk of persistently high spending that was modifiable by complex care management.

Third, engagement via telephonic outreach failed to reach many patients. About 40% of the patients randomized to complex care management could not be contacted by telephone. Medicaid patients often have missing or outdated contact information because of numerous structural barriers including poverty and housing insecurity.[53,54] Strategies that incorporate alternative forms of outreach (eg, in-person, text message, email) and partnerships with community organizations could improve engagement among this population.

Finally, the design and implementation of the program incorporated attributes of successful complex care management programs in other populations.[11,13,20,21,30] These included identifying patients at high risk of poor outcomes and avoidable spending; conducting comprehensive assessments of medical, social, and behavioral risk; care planning and routine follow-up; interdisciplinary, team-based care; and the use of CHWs to engage and activate patients, build trust, and better understand and manage the nonmedical drivers of poor outcomes. The results of this study confirm the importance of these attributes, but it remains unclear which attributes are more or less responsible for the observed reductions in spending and utilization. Larger evaluations, with factorial designs or well-powered subgroup analyses, could help clarify which attributes are most effective.

Limitations

This study has several limitations. First, as it was a pragmatic quality improvement trial, the scope was limited to a relatively small population (n = 198). Second, patients with cognitive impairment, severe mental illness without medical comorbidity, active malignancy, or pregnancy, as well as those residing in long-term care facilities, were excluded from the study population. As a result, the findings may not be generalizable to other high-need, high-cost Medicaid populations, and larger replication studies are warranted. Third, many patients were lost to follow-up. Although the rates were similar across both study groups (roughly 20%), if the patients lost to follow-up in each group were systematically different, the results may be biased. Fourth, the analysis was limited to 12-month spending and utilization outcomes. We were unable to evaluate the impact of the program on health-related outcomes or longer-term spending and utilization trends. Future research is needed to better understand the impact of complex care management on morbidity, mortality, measures of disease control, and the durability of spending and utilization reductions. Finally, we did not collect detailed information on processes outcomes or program fidelity. This limited our ability to understand which program attributes were most responsible for the observed spending and utilization reductions.

CONCLUSIONS

Complex care management programs have proliferated in recent years, but little is known about their impact in high-need, high-cost Medicaid populations. The results of this study suggest that complex care management can reduce spending and acute care utilization. Precise patient targeting, the use of nontraditional healthcare workers such as CHWs, and in-person engagement strategies may improve the efficacy and efficiency of complex care management programs for Medicaid patients. ■

Acknowledgments

This study was presented in part at the AcademyHealth Annual Research Meeting; June 3, 2019; Washington, DC. The authors would like to acknowledge Brisa Samudio (formerly of CareMore Health) and Yolanda Sutton (CareMore Health) for their tireless work on behalf of CareMore's high-need, high-cost patients, and Caroline Hagan (CareMore Health) and Paula Ma (CareMore Health) for their assistance with data preparation.

Author Affiliations: CareMore Health (BWP, FM, SP, NM, SHJ, VG), Cerritos, CA; Brigham and Women's Hospital (BWP), Boston, MA; Department of Population Medicine, Harvard Medical School (BWP), Boston, MA; Academic Institute, Atrius Health (BWP), Boston, MA; Community Health Group (MS), San Diego, CA; Stanford University School of Medicine (SHJ), Stanford, CA.

Source of Funding: None.

Author Disclosures: Drs Powers, Modarai, and Jain are employees of CareMore Health/Anthem. Dr Modarai owns stock in Anthem as part of his employment. The remaining authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (BWP, FM, SP, MS, VG); acquisition of data (BWP, FM, SP, MS); analysis and interpretation of data (BWP, FM, NM); drafting of the manuscript (BWP, FM, SP, NM); critical revision of the manuscript for important intellectual content (BWP, SP, NM, SHJ, VG); statistical analysis (BWP); provision of patients or study materials (FM, MS, SHJ); obtaining funding (SHJ); administrative, technical, or logistic support (BWP, FM, SP, MS, SHJ); and supervision (BWP, MS, NM, SHJ, VG).

Address Correspondence to: Brian W. Powers, MD, MBA, Harvard Medical School, 75 Francis St, Boston, MA 02446. Email: brian_powers@hms.harvard.edu.

REFERENCES

1. Figueroa JF, Joynt Maddox KE, Beaulieu N, Wild RC, Jha AK. Concentration of potentially preventable spending among high-cost Medicare subpopulations: an observational study. *Ann Intern Med*. 2017;167(10):706-713. doi: 10.7326/M17-0767.
2. Figueroa JF, Frakt AB, Lyon ZM, Zhou X, Jha AK. Characteristics and spending patterns of high cost, non-elderly adults in Massachusetts. *Healthc (Amst)*. 2017;5(4):165-170. doi: 10.1016/j.hjdsi.2017.05.001.
3. Blumenthal D, Abrams MK. Tailoring complex care management for high-need, high-cost patients. *JAMA*. 2016;316(16):1657-1658. doi: 10.1001/jama.2016.12388.
4. Blumenthal D, Chernof B, Fulmer T, Lumpkin J, Selberg J. Caring for high-need, high-cost patients—an urgent priority. *N Engl J Med*. 2016;375(10):909-911. doi: 10.1056/NEJMp1608511.
5. Ryan J, Abrams MK, Doty MM, Shah S, Schneider EC. How high-need patients experience health care in the United States: findings from the 2016 Commonwealth Fund Survey of High-Need Patients. *Issue Brief (Commonw Fund)*. 2016;43:1-20.
6. Hayes SL, Salzburg CA, McCarthy D, et al. High-need, high-cost patients: who are they and how do they use health care? The Commonwealth Fund website. commonwealthfund.org/publications/issue-briefs/2016/aug/high-need-high-cost-patients-who-are-they-and-how-do-they-use. Published August 29, 2016. Accessed March 7, 2019.
7. Salzburg CA, Hayes SL, McCarthy D, et al. Health system performance for the high-need patient: a look at access to care and patient care experiences. The Commonwealth Fund website. commonwealthfund.org/publications/issue-briefs/2016/aug/health-system-performance-high-need-patient-look-access-care-and. Published August 29, 2016. Accessed March 7, 2019.
8. Long P, Abrams M, Milstein A, et al, eds. *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health*. Washington, DC: National Academy of Medicine; 2017.
9. Hong CS, Abrams MK, Ferris TG. Toward increased adoption of complex care management. *N Engl J Med*. 2014;371(6):491-493. doi: 10.1056/NEJMp1401755.

10. Powers BW, Chaguturu SK, Ferris TG. Optimizing high-risk care management. *JAMA*. 2015;313(8):795-796. doi: 10.1001/jama.2014.18171.
11. McCarthy D, Ryan J, Klein S. Models of care for high-need, high-cost patients: an evidence synthesis. The Commonwealth Fund website. commonwealthfund.org/publications/issue-briefs/2015/oct/models-care-high-need-high-cost-patients-evidence-synthesis. Published October 29, 2015. Accessed May 9, 2019.
12. Goodell S, Bodenheimer TS, Berry-Millett R. Care management of patients with complex health needs. Robert Wood Johnson Foundation website. rwjf.org/en/library/research/2009/12/care-management-of-patients-with-complex-health-care-needs.html. Published December 1, 2009. Accessed May 9, 2019.
13. Hong CS, Siegel AL, Ferris TG. Caring for high-need, high-cost patients: what makes for a successful care management program? *Issue Brief (Commonw Fund)*. 2014;19:1-19.
14. Peck KA, Usadi B, Mainor A, Newton H, Meara E. How ACOs are caring for people with complex needs. The Commonwealth Fund website. commonwealthfund.org/publications/fund-reports/2018/dec/how-acos-are-caring-people-complex-needs. Published December 11, 2018. Accessed May 9, 2019.
15. Nelson L. Lessons from Medicare's demonstration projects on disease management and care coordination. Congressional Budget Office website. cbo.gov/sites/default/files/cbofiles/attachments/WP2012-01_Nelson_Medicare_DMCC_Demonstrations.pdf. Published January 2012. Accessed May 9, 2019.
16. Peikes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. *JAMA*. 2009;301(6):603-618. doi: 10.1001/jama.2009.126.
17. Stokes J, Panagioti M, Alam R, Checkland K, Cheraghi-Sohi S, Bower P. Effectiveness of case management for "at risk" patients in primary care: a systematic review and meta-analysis. *PLoS One*. 2015;10(7):e0132340. doi: 10.1371/journal.pone.0132340.
18. Hsu J, Price M, Vogeli C, et al. Bending the spending curve by altering care delivery patterns: the role of care management within a Pioneer ACO. *Health Aff (Millwood)*. 2017;36(5):876-884. doi: 10.1377/hlthaff.2016.0922.
19. Urato C, McCall N, Cromwell J, Lenfestey N, Smith N, Raeder D. Evaluation of the Extended Medicare Care Management for High Cost Beneficiaries (CMHCB) demonstration: Massachusetts General Hospital and Massachusetts General Physicians Organization (MGH). CMS website. innovation.cms.gov/files/reports/cmhcb-massgen.pdf. Published October 2013. Accessed May 9, 2019.
20. Brown RS, Peikes D, Peterson G, Schore J, Razafindrakoto CM. Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Aff (Millwood)*. 2012;31(6):1156-1166. doi: 10.1377/hlthaff.2012.0393.
21. Bodenheimer T. Strategies to reduce costs and improve care for high-utilizing Medicaid patients: reflections on pioneering programs. Center for Health Care Strategies, Inc, website. chcs.org/resource/strategies-to-reduce-costs-and-improve-care-for-high-utilizing-medicaid-patients-reflections-on-pioneering-programs/. Published October 2013. Accessed March 7, 2019.
22. Berkowitz SA, Parashuram S, Rowan K, et al; Johns Hopkins Community Health Partnership (J-CHiP) Team. Association of a care coordination model with health care costs and utilization: the Johns Hopkins Community Health Partnership (J-CHiP). *JAMA Netw Open*. 2018;1(7):e184273. doi: 10.1001/jamanetworkopen.2018.4273.
23. Shah T, Corrine L, Tsega M, Abrams MK. Quick reference guide to promising care models for patients with complex needs. The Commonwealth Fund website. commonwealthfund.org/publications/2019/feb/care-models-patients-complex-needs. Published February 20, 2019. Accessed May 9, 2019.
24. Hostetter M, Klein S, McCarthy D. Hennepin Health: a care delivery paradigm for new Medicaid beneficiaries. The Commonwealth Fund website. commonwealthfund.org/publications/case-study/2016/oct/hennepin-health-care-delivery-paradigm-new-medicaid-beneficiaries. Published October 7, 2016. Accessed May 9, 2019.
25. Charlson ME, Wells MT, Kanna B, Dunn V, Michelen W. Medicaid managed care: how to target efforts to reduce costs. *BMC Health Serv Res*. 2014;14:461. doi: 10.1186/1472-6963-14-461.
26. Jiang HJ, Barrett ML, Sheng M. Characteristics of hospital stays for nonelderly Medicaid super-utilizers, 2012. Healthcare Cost and Utilization Project website. hcup-us.ahrq.gov/reports/statbriefs/sb184-Hospital-Stays-Medicaid-Super-Utilizers-2012.pdf. Published November 2014. Accessed May 9, 2019.
27. Graven PF, Meath THA, Mendelson A, Chan BKS, Dorr DA, McConnell KJ. Preventable acute care spending for high-cost patients across payer types. *J Health Care Finance*. 2016;42(3).
28. Powers BW, Chaguturu SK. ACOs and high-cost patients. *N Engl J Med*. 2016;374(3):203-205. doi: 10.1056/NEJMp1511131.
29. Coughlin TA, Long SK. Health care spending and service use among high-cost Medicaid beneficiaries, 2002-2004. *Inquiry*. 2009;46(4):405-417. doi: 10.5034/inquiryjrnl_46.4.405.
30. Anderson GF, Ballreich J, Bleich S, et al. Attributes common to programs that successfully treat high-need, high-cost individuals. *Am J Manag Care*. 2015;21(11):e597-e600.
31. Vogeli C, Spirt J, Brand R, et al. Implementing a hybrid approach to select patients for care management: variations across practices. *Am J Manag Care*. 2016;22(5):358-365.
32. Freund T, Gondan M, Rochon J, et al. Comparison of physician referral and insurance claims data-based risk prediction as approaches to identify patients for care management in primary care: an observational study. *BMC Fam Pract*. 2013;14:157. doi: 10.1186/1471-2296-14-157.
33. Freund T, Wensing M, Geissler S, et al. Primary care physicians' experiences with case finding for practice-based care management. *Am J Manag Care*. 2012;18(4):e155-e161.
34. Hong C, Hwang A, Ferris T. Finding a match: how successful complex care programs identify patients. California Health Care Foundation website. chcf.org/publication/finding-a-match-how-successful-complex-care-programs-identify-patients. Published March 6, 2015. Accessed March 5, 2019.
35. Lloyd J, Thomas-Henkel C. Integrating community health workers into complex care teams: key considerations. Center for Health Care Strategies, Inc, website. chcs.org/resource/integrating-community-health-workers-complex-care-teams-key-considerations. Published May 2017. Accessed May 9, 2019.
36. Kangovi S, Mitra N, Norton L, et al. Effect of community health worker support on clinical outcomes of low-income patients across primary care facilities: a randomized clinical trial. *JAMA Intern Med*. 2018;178(12):1635-1643. doi: 10.1001/jamainternmed.2018.4630.
37. Kangovi S, Mitra N, Grande D, et al. Patient-centered community health worker intervention to improve posthospital outcomes: a randomized clinical trial. *JAMA Intern Med*. 2014;174(4):535-543. doi: 10.1001/jamainternmed.2013.14327.
38. Thompson MP, Podila PSB, Clay C, et al. Community navigators reduce hospital utilization in super-utilizers. *Am J Manag Care*. 2018;24(2):70-76.
39. Viswanathan M, Kraschnewski JL, Nishikawa B, et al. Outcomes and costs of community health worker interventions: a systematic review. *Med Care*. 2010;48(9):792-808. doi: 10.1097/MLR.0b013e3181e35b51.
40. Kim K, Choi JS, Choi E, et al. Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: a systematic review. *Am J Public Health*. 2016;106(4):e3-e28. doi: 10.2105/AJPH.2015.302987.
41. Jack HE, Arabadjis SD, Sun L, Sullivan EE, Phillips RS. Impact of community health workers on use of healthcare services in the United States: a systematic review. *J Gen Intern Med*. 2017;32(3):325-344. doi: 10.1007/s11606-016-3922-9.
42. Intensive Outpatient Care Program (IOCP) toolkit: Pacific Business Group on Health. California Quality Collaborative website. calquality.org/storage/documents/IOCPPCC_Toolkit_V7_112216.pdf. Updated December 2016. Accessed March 6, 2019.
43. Austin PC. An introduction to propensity score methods for reducing the effects of confounding in observational studies. *Multivariate Behav Res*. 2011;46(3):399-424. doi: 10.1080/00273171.2011.568786.
44. Stuart EA. Matching methods for causal inference: a review and a look forward. *Stat Sci*. 2010;25(1):1-21. doi: 10.1214/09-STS313.
45. Austin PC. Using the standardized difference to compare the prevalence of a binary variable between two groups in observational research. *Commun Stat Simul Comput*. 2009;38(6):1228-1234. doi: 10.1080/03610910902859574.
46. Holm S. A simple sequentially rejective multiple test procedure. *Scand J Stat*. 1979;6(2):65-70.
47. Sinaiko AD, Landrum MB, Meyers DJ, et al. Synthesis of research on patient-centered medical homes brings systematic differences into relief. *Health Aff (Millwood)*. 2017;36(3):500-508. doi: 10.1377/hlthaff.2016.1235.
48. Friedberg MW, Schneider EC, Rosenthal MB, Volpp KG, Werner RM. Association between participation in a multipayer medical home intervention and changes in quality, utilization, and costs of care. *JAMA*. 2014;311(8):815-825. doi: 10.1001/jama.2014.353.
49. Finkelstein AN, Taubman SL, Allen HL, Wright BJ, Baicker K. Effect of Medicaid coverage on ED use—further evidence from Oregon's experiment. *N Engl J Med*. 2016;375(16):1505-1507. doi: 10.1056/NEJMp1609533.
50. Taubman SL, Allen HL, Wright BJ, Baicker K, Finkelstein AN. Medicaid increases emergency-department use: evidence from Oregon's health insurance experiment. *Science*. 2014;343(6168):263-268. doi: 10.1126/science.1246183.
51. Johnson TL, Rinehart DJ, Durfee J, et al. For many patients who use large amounts of health care services, the need is intense yet temporary. *Health Aff (Millwood)*. 2015;34(8):1312-1319. doi: 10.1377/hlthaff.2014.1186.
52. Chakravarty S, Cantor JC. Informing the design and evaluation of superuser care management initiatives: accounting for regression-to-the-mean. *Med Care*. 2016;54(9):860-867. doi: 10.1097/MLR.0000000000000568.
53. Barth S, Ensslin B. Contacting hard-to-locate Medicare and Medicaid members: tips for health plans. Center for Health Care Strategies, Inc, website. chcs.org/media/PRIDE-Tips-for-Contacting-Hard-to-Locate-Members_121014_2.pdf. Published December 2014. Accessed May 9, 2019.
54. Artiga S, Rudowitz R, Tolbert J. Outreach and enrollment strategies for reaching the Medicaid eligible but uninsured population. Kaiser Family Foundation website. kff.org/medicaid/issue-brief/outreach-and-enrollment-strategies-for-reaching-the-medicaid-eligible-but-uninsured-population. Published March 2, 2016. Accessed May 9, 2019.

Visit **ajmc.com/link/4487** to download PDF and eAppendix

eAppendix for "Impact of Complex Care Management on Spending and Utilization for High-Need, High-Cost Medicaid Patients: A Randomized Quality Improvement Trial"

Brian W. Powers, MD, MBA
Farhad Modarai, DO
Sandeep Palakodeti, MD, MPH
Manisha Sharma, MD
Nupur Mehta, MD
Sachin H. Jain, MD, MBA
Vivek Garg, MD, MBA

(1) Unadjusted Spending and Utilization Outcomes
(2) Appointment Kept Rates
(3) Patient Vignettes

(1) Unadjusted Spending and Utilization Outcomes

	Complex Care Management	Usual Care	Difference (95% CI)	P Value[a]
Primary Outcomes				
TME ($/patient/yr)	11,567	21,674	-10,108 (-18,071, -2,143)	0.013
IP Days (#/patient/yr)	2.13	6.25	-4.13 (-4.68, -3.57)	<0.001
Secondary Outcomes				
IP Admissions (#/patient/yr)	0.38	0.76	-0.38 (-0.59, -0.17)	0.001
ED Visits (#/patient/yr)	2.69	2.83	-0.14 (-0.63, 0.34)	1.000
Care Center Visits (#/patient/yr)	4.55	4.46	0.09 (-0.52, 0.71)	1.000
Specialist Visits (#/patient/yr)	3.92	5.55	-1.64 (-2.25, -1.02)	<0.001

[a] Adjusted for multiple comparisons (Holm-Bonferroni)

Abbreviations: TME = total medical expenditures; IP = inpatient; ED = emergency department.

(2) Selected Appointment Kept Rates

Appointment	Kept Rate
Intake Visit	87%
30 Day Visit	87%
60 Day Visit	100%
90 Day Visit	95%

NOTE: Due to changes in information systems, monthly appointment kept rates were not routinely tracked after 90 days.

(3) Patient Vignettes

Ms. T

- *History:* 58-year-old woman with hypertension, diabetes, anxiety, post-traumatic stress disorder, domestic violence, and substance use disorder. Frequent ED visits for substance use and behavioral health needs.
- *Intervention:* Discovered extensive prior trauma from domestic violence. Built trust with patient through a trauma-informed approach, which ultimately led to re-engagement with psychiatry and enrollment in a substance use disorder treatment program.
- *Impact*: ED visits fell from 11 to 1. Total medical expenditures decreased by $72,367.

Mr. R

- *History:* 59-year-old man with congestive heart failure, hypertension, diabetes, chronic pain, and depression. Frequent hospitalizations for heart failure exacerbations.
- *Intervention:* Screening uncovered he was living in his friend's garage due to an inability to pay utility bills. He had been unable to prioritize attending cardiology appointments given housing instability. CHW arranged for utility bill payments through a combination of donations and a payment plan, and he was able to move back into his home.
- *Impact:* Cardiology visits increased from 1 to 8. Inpatient bed days decreased from 41 to 9

Mr. S

- *History:* 45-year-old man with bilateral above the knee amputations and multiple, chronic, high-risk wounds. Frequent inpatient admissions for wound care and infections.
- *Intervention:* Discovered home health nurses would not see patient due to concerns for gang-related activity in the home and risk of violence in the neighborhood. Arranged for transportation and wound-care visits at the care center.
- *Impact:* Inpatient bed days fell from 51 to 0. Total medical expenditures decreased by $28,723

COMMENTARY

Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals

Gerard F. Anderson, PhD; Jeromie Ballreich, MHS; Sara Bleich, PhD; Cynthia Boyd, MD; Eva DuGoff, PhD; Bruce Leff, MD; Claudia Salzburg, PhD; and Jennifer Wolff, PhD

ABSTRACT

Using literature review and interviews, we have identified 8 attributes of programs, such as accountable care organizations, readmission initiatives, special needs plans, care transition programs, and patient-centered medical homes, that successfully treat high-need, high-cost patients. These 8 attributes—illustrated here with specific examples—are specific ways to target these types of individuals, promote leadership at various levels, emphasize interaction with the care coordinator, use data strategically to refine the program, update the program periodically, allow physicians to spend more time with patients, and promote interaction among clinicians and high-need, high cost patients and their families.

Am J Manag Care. 2015;21(11):e597-e600

The United States has tried, and continues to experiment with, many different programs designed to provide better care for people with high needs and high costs. These programs include accountable care organizations, readmission initiatives, special needs plans, care transition programs, patient-centered medical homes, and many others. These programs have been evolving over the past 20 years with many of the initiatives based loosely on the Chronic Care Model developed by Ed Wagner and his colleagues.[1] We wanted to identify specific attributes of successful programs for this population.

ajmc.com © Managed Care & Healthcare Communications, LLC

Common Attributes of Successful Programs

In order to identify the attributes that successful programs have in common, we began by reviewing the peer-reviewed literature evaluating the various programs and subsequently identified over 1000 articles that were written about programs designed to treat adults with high costs and/or high needs in the United States. To be included in the review, the study had to involve 2 or more chronic conditions or a chronic condition and a disability.

However, we quickly realized that many programs being used to guide policy are not in the peer-reviewed literature. These include programs sponsored by the Medicare and Medicaid, Veterans Administration, private insurers or health plans, and doctors or hospitals. We used the information from both the peer-reviewed literature and the gray literature to: 1) identify specific programs that focus on high-need, high-cost individuals that were successful on at least 1 of the 3 triple aims (spending, satisfaction, clinical outcomes), and 2) to identify commonalities of success in these programs.

We became especially interested in why certain programs had varying levels of success in different settings and populations. We created a semi-structured interview guide and interviewed 45 programs that the peer-reviewed literature and/or gray literature identified as successful on at least 1 of the triple aims.

Take-Away Points

Many of the attempts to design programs for high-need, high-cost patients have been unable to achieve even 1 of the triple aims. In this article, we examine the published literature, government reports, and reports by managed care organizations, hospitals, and physician groups to identify the commonalities of successful programs. The 8 attributes of successful programs we identified are: appropriate targeting of high-risk patients, inclusive leadership, appropriate sizing of program, adapting to local conditions, providing helpful feedback to clinicians, promoting interaction with patients and family members, fostering successful care transitions, and reducing the workload of clinicians. This article will allow policy makers to:

- Compare their programs to the attributes of successful programs.
- Assess if modifications to their programs are needed.
- Determine if they should partner with certain existing programs.
- Design the next generation of programs.

Commonalities of Successful Programs

Based on the literature review and the interviews, we identified 8 attributes that many successful programs shared. An example of each specific program that typifies each attribute is provided in the Table.

Targeting

Many successful programs use 2 steps to identify which individuals to include in the program and who should receive special attention. Many unsuccessful programs enroll a high percentage of people who are unlikely to benefit from the intervention; for example, the enrollment of people with only a single chronic disease.[2] Second, some programs provide the same services to all people enrolled in the program; however, the more successful programs typically stratify program enrollees and provide additional services to certain high-need, high-cost individuals.[3]

Nevertheless, simply being high-need/high-cost is not always sufficient.[4] Many patients have conditions that are not amenable to change. For example, some cancer patients may require expensive drugs and the drug use is appropriate for their condition. An intervention will not necessarily lower the spending for that person. Other patients are unwilling to comply with treatment protocols. Being able to identify those who are most likely to benefit from an intervention is an understudied area and may be responsible for the lack of success in many programs. The key is to identify those patients most amenable to change.

Leadership

Most successful programs have leadership at varying levels of the organization, not simply at the top. It is important that the leadership team span a wide range of clinical and operational disciplines, including physicians, nurses, social workers, pharmacy, and operations. Finding successful care managers and facilitating their relationship with other clinical practitioners and non-clinical professionals, such as community health workers, is a critical role for leadership. The care managers must have the skills to be assertive when necessary, to understand the practice culture in the setting, and to maintain good relationships with physicians, other clinicians, and administrators caring for the patient.[5] With this in mind, some programs have developed their own training programs for care managers.[6]

Interaction With the Care Coordinator

Some programs involve teams of nurses and social workers working remotely, primarily using the telephone or e-mail. Although some of these programs are successful, most are not, probably because they have not developed close relationships with the clinicians treating the patient, the patient and the family members.[2] Although the initial expense is greater, successful programs are more likely to have care coordinators located in the physician's office. Physical proximity is only a first step, however; it may be necessary for all clinicians, including specialists, to personally know each other. Developing an ongoing working relationship is important, and often this requires frequent face-to-face interactions about a specific patient, especially with specialty physicians.[4] It was often more difficult to develop these personal relationships in large fee-for-service organizations, like academic medical centers or large hospitals, where there were a multitude of people treating the patient[7]; it was much easier in smaller multidisciplinary physician groups, where a care coordinator was embedded in the office, as well as in larger organizations like Kaiser Permanente, where teams of clinicians routinely worked together as a group.

Strategic Use of Data

Both electronic medical records (EMRs) and claims data have been utilized successfully in the treatment of high-need, high-cost individuals. The advantage of relying on EMRs is that the data is available in real time, which is often when the information is most actionable. However, EMRs are often not interoperable and, therefore, it is difficult to assemble a complete picture of the patient if the patient is receiving care at multiple sites. Claims data is often more complete, and the Medicare program has begun to provide claims data to programs on a monthly basis.

Providing timely data to the care team is vital.[8] However, it is unclear how timely the data needs to be or exactly which data elements are the most critical. Many clinicians do not respond to cost information about individual pa-

tients or know how to respond to information about readmission rates. In addition, finding relevant data for high-need, high-cost patients is problematic because determining the appropriate care for them is challenging—most quality metrics focus on a single disease, not the ability to coordinate care for complex patients.[9] Data customization for specific types of patients also presents a challenge. For example, people near the end of their life require a different data set from those with psychological or social issues, and a different data set from those undergoing a transition from one setting to another.

Interaction With Patients and Families

Successful programs seem to be more facile at interacting with patients and their families.[10] In most successful programs, the care coordinator is located in the doctor's office and has a wide range of clinical and social service responsibilities.[11] They often: 1) see the patient when he or she arrives to see the doctor and ask about their priorities for care, 2) make periodic home visits, 3) occasionally interact with the patient's family, and 4) to some extent, interact with the specialists caring for the patient. Interaction with patients is especially critical during and following the hospital stay. A patient's medications can change following physician and hospital visits, so it is often necessary for the care coordinator to explain the change in medications directly to the patient.

Also important are ongoing interactions with the social service programs since many high-need, high-cost high patients have disabilities that make it difficult for them to undertake routine activities of daily living. Both nurses and social workers seem to be successful care coordinators. In general, more in-person interaction between the patient and the care coordinator results in better outcomes and lower overall spending.[12] Remote monitoring programs are less likely to achieve the triple aim.[2] A paper synthesizing the evaluations of Medicare programs that treat the high-need, high-cost population found that 1 contact per month with the care coordinator is the minimum necessary for a successful program.[4]

Table. Successful Attributes and Program Examples

Attribute	Program Example
Ability to target high-cost, high-need patients	**Medicare Coordinated Care Demonstration, the Washington University School of Medicine in St. Louis** After a change in practice, care management efforts focused on patients deemed at greatest risk of hospitalization.
Create environment for successful leadership at all levels	**Medicare Care Management for High-Cost Beneficiaries (CMHCB) Demonstration: Mass General Hospital** This program employed physician champions that advocated the program. In addition, every two weeks, the team spends 2 hours together for a case review.
Structure the size of program to facilitate communication	**Guided Care** Guided care was more successful in Kaiser Permanente than it was at Johns Hopkins community-based ambulatory practices.
Adapt the program to reflect local and changing circumstances	**Medicare Coordinated Care Demonstration** Sites were able to adapt and revise during the demonstration process to improve process of care and targeting techniques.
Provide important feedback to clinicians and care coordinators	**Baptist ACE** The score card, which was developed by physicians, contained over 40 aggregate scores on quality measures which represented 10 domains (each domain had 3 or 4 measures). Physicians received their report cards monthly, with detailed information at both the patient and diagnosis-related group level.
Foster effective interactions with patients	**Care Oregon** The health plan changed its relationship with the network to make the care point-of-service–based, whereas historically, care management has been outside of the delivery system (eg, through phones).
Focus on care transitions	**Arkansas Pediatric Hospital** Program targeted medically complex children and made a strong effort for the coordinating team to be an "anchor" and ensure continuity of care.
Develop programs that reduce workload of physicians	**Medicare Care Management for High-Cost Beneficiaries (CMHCB) Demonstration: Mass General Hospital** While MDs did not necessarily gain financially from participating in the program, they benefited from a reduced workload that allowed them to spend less time caring for a panel of patients.

Periodic Updates

Most successful programs evolve over time.[13] The challenge here is periodically updating the program to reflect new information about what is working, and responding adequately to the changing mix of high-need, high-cost

individuals participating in the program. It appears to be important for care managers and clinicians to have enough flexibility to initiate program innovations at certain internals, but there does not seem to be a standard timeline for updating the program. It is clear that many programs treating high-need, high-cost individuals require a long period of sustained funding before the program becomes cost-saving.

More Time With Patients

There are a multitude of programs with different financial incentives for physicians. Many of them provide rather modest financial incentives for the physicians and may represent a relatively small portion of the physicians' total patients. As a result, changing the financial incentives is frequently an unsuccessful strategy. Instead of dollars, an appeal to the physician's work-life balance is often more effective.[5] Care coordinators are able to simplify the work of clinicians by facilitating the interaction with other physicians treating the patient, meeting with family members, explaining changes to treatment protocols with patients, interacting with social service agencies to make sure the patient has necessary services, and many other roles that the physicians frequently perform. This allows the physician to spend more time with their patients and to perhaps leave the office earlier in the day.

Summary and Recommendations

Governments, health plans, and clinicians will soon be developing the next generation of programs designed to treat high-need, high-cost individuals. The reasons are clear: they are the most costly individuals who often have the worst clinical outcomes. The problem is, most of the interventions that have been attempted have not yet been able to achieve 1 or more of the triple aims, and many of those that have been reported in the peer-reviewed literature as being successful in this were not operational a few years later. The current evidence suggests that programs that share certain attributes are more likely to be successful and sustainable. These attributes are shown in the Table. These attributes are meant as guidelines for governments, health plans, and clinicians to consider as they develop the next generation of programs. Whereas all are important, perhaps the most important is identifying the patients most likely to benefit from the program and then targeting the program around these individuals.

Author Affiliations: Johns Hopkins Bloomberg School of Public Health (GFA, JB, SB, CS, JW), Baltimore, MD; Johns Hopkins School of Medicine (CB, BL), Baltimore, MD; University of Wisconsin – Madison (ED), Madison, WI.

Source of Funding: The Commonwealth Fund.

Author Disclosures: Dr Leff is member of the board for American Academy Home Care Medicine and a member of the advisory board for Landmark Health. Dr Boyd received royalties as author of book chapter on multimorbidity from UpToDate. The remaining authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (GFA, CS, BL, JW); acquisition of data (GFA, JB, ED, BL, CS); analysis and interpretation of data (GFA, CB, JB, SB, BL, CS, JW); drafting of the manuscript (GFA, JB, SB, ED, CS); critical revision of the manuscript for important intellectual content (GFA, CB, SB, ED, BL, JW); statistical analysis (GFA); provision of patients or study materials (GFA); obtaining funding (GFA); administrative, technical, or logistic support (GFA, JB, ED); and supervision (GFA).

Address correspondence to: Gerard Anderson, PhD, Department of Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University, 624 North Broadway, Baltimore, MD 21205. E-mail: Ganderson@jhu.edu.

REFERENCES

1. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. *Milbank Q.* 1996;74(4):511-544.
2. Bott DM, Kapp MC, Johnson LB, Magno LM. Disease management for chronically ill beneficiaries in traditional Medicare. *Health Aff (Millwood).* 2009;28(1):86-98.
3. Boult C, Green AF, Boult LB, Pacala JT, Snyder C, Leff B. Successful models of comprehensive care for older adults with chronic conditions: evidence for the Institute of Medicine's "retooling for an aging America" report. *J Am Geriatr Soc.* 2009;57(12):2328-2337.
4. Brown RS, Peikes D, Peterson G, Schore J, Razafindrakoto CM. Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Aff (Millwood).* 2012;31(6):1156-1166.
5. Hong CS, Siegel AL, Ferris TG. Caring for high-need, high-cost patients: what makes for a successful care management program? *Issue Brief (Commonw Fund).* 2014;19:1-19.
6. Wolff JL, Rand-Giovannetti E, Palmer S, et al. Caregiving and chronic care: the guided care program for families and friends. *J Gerontol A Biol Sci Med Sci.* 2009;64(7):785-791.
7. Boult C, Karm L, Groves C. Improving chronic care: the "guided care" model. *Perm J.* 2008;12(1):50-54.
8. McCall N, Cromwell J. Results of the Medicare Health Support disease-management pilot program. *N Engl J of Med.* 2011;365(18):1704-1712.
9. Boyd CM, Leff B, Wolff JL, et al. Informing clinical practice guideline development and implementation: prevalence of coexisting conditions among adults with coronary heart disease. *J Am Geriatr Soc.* 2011;59(5):797-805.
10. Wolff JL, Giovannetti ER, Boyd CM, et al. Effects of guided care on family caregivers. *Gerontologist.* 2010;50(4):459-470.
11. Naylor MD, Brooten DA, Campbell RL, Maislin G, McCauley KM, Schwartz JS. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *J Am Geriatr Soc.* 2004;52(5):675-684.
12. Boult C, Reider L, Leff B, et al. The effect of guided care teams on the use of health services: results from a cluster-randomized controlled trial. *Arch Intern Med.* 2011;171(5):460-466.
13. Peikes D, Peterson F, Brown RS, Graff S, Lynch JP. How changes in Washington University's Medicare coordinated care demonstration pilot ultimately achieved savings. *Health Aff (Millwood).* 2012;31(6):1216-1226. ■

www.ajmc.com Full text and PDF

ISSUE: Care Management Services: CCM, CCCM & PCM

TAB: 25

Source	CPT	Global	Descriptor	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME 3DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered services provided by a	10	0.037	0.030			1.73			57	10				32			15					
2nd REF	99497	XXX	Advance care planning including the explanation and discussion of advance directives such as	9	0.039	0.033			1.50			45	5				30			10					
CURRENT	99490	XXX	Chronic care management services, at least 20 minutes of clinical staff time directed by a		0.041	0.041			0.61			15					15								
SURVEY	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	84	0.048	0.048	0.40	1.00	1.20	1.52	60.00	25			1	20	25	30	60		0	1	12	50	800
REC	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month		0.040	0.040			1.00			25					25								

Source	CPT	Global	Descriptor	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME 3DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99231	XXX	Subsequent hospital care, per day, for the evaluation and management of a patient, which	9	0.054	0.038			0.76			20	5				10			5					
2nd REF	99457	XXX	Remote physiologic monitoring treatment management services, 20 minutes or more of	8	0.031	0.031			0.61			20					20								
2nd REF	99238	XXX	Hospital discharge day management; 30 minutes or less	8	0.044	0.034			1.28			38	8				20			10					
CURRENT	99439	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal month		0.041	0.041			0.61			15					15								
CURRENT	G2058	ZZZ	Chronic care management services, each additional 20 minutes of clinical staff time		0.036	0.036			0.54			15					15								
SURVEY	99439	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal month	75	0.047	0.047	0.20	0.70	0.93	1.10	20.00	20			5	20	20	30	70		0	0	5	20	500
REC	99439	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal month		0.035	0.035			0.70			20					20								

Source	CPT	Global	Descriptor	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME 3DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered services provided by a	14	0.037	0.030			1.73			57	10				32			15					
2nd REF	99239	XXX	Hospital discharge day management; more than 30 minutes	7	0.045	0.035			1.90			55	10				30			15					
CURRENT	99491	XXX	Chronic care management services, provided personally by a physician or other qualified		0.048	0.048			1.45			30					30								
SURVEY	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	55	0.054	0.054	0.50	1.50	1.75	2.00	75.00	32.5			14	30	33	41	145		0	0	5	23	500
REC	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month		0.045	0.045			1.50			33					33								

Source	CPT	Global	Descriptor	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME 3DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered services provided by a	10	0.037	0.030			1.73			57	10				32			15					
2nd REF	99498	ZZZ	Advanced Care Planning, each additional 30 minutes	5	0.047	0.047			1.40			30					30								
SURVEY	99437	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	48	0.043	0.043	0.40	1.00	1.29	1.73	20.00	30			10	20	30	35	5280		0	0	1	15	100
REC	99437	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month		0.033	0.033			1.00			30					30								

ISSUE: Care Management Services: CCM, CCCM & PCM

TAB: 25

Source	CPT	Global	Descriptor	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME 3DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered services provided by a	12	0.037	0.030			1.73			57	10				32			15					
2nd REF	99226	XXX	Subsequent observation care, per day, for the evaluation and management of a patient, which	8	0.048	0.036			2.00			55	10				30			15					
CURRENT	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month		0.038	0.038			1.00			26					26								
SURVEY	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	51	0.047	0.047	0.43	1.81	2.10	2.50	100.00	45			1	30	45	60	90		0	0	5	30	500
REC	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month		0.040	0.040			1.81			45					45								

Source	CPT	Global	Descriptor	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME 3DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered services provided by a	7	0.037	0.030			1.73			57	10				32			15					
2nd REF	99457	XXX	Remote physiologic monitoring treatment management services, 20 minutes or more of	7	0.031	0.031			0.61			20					20								
CURRENT	99489	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal month		0.038	0.038			0.50			13					13								
SURVEY	99489	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal month	51	0.040	0.040	0.40	1.00	1.20	1.70	20.00	30			6	20	30	35	91		0	0	2	15	200
REC	99489	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal month		0.033	0.033			1.00			30					30								

Source	CPT	Global	Descriptor	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME 3DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99226	XXX	Subsequent observation care, per day, for the evaluation and management of a patient, which	8	0.048	0.036			2.00			55	10				30			15					
2nd REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered services provided by a	7	0.037	0.030			1.73			57	10				32			15					
CURRENT CMS/OTHER	G2064	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month		0.048	0.048			1.45			30					30								
SURVEY	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	53	0.054	0.054	0.40	1.45	1.73	2.00	10.00	32			7	30	32	42	3696		0	0	10	32	1000
REC	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month		0.045	0.045			1.45			32					32								

Source	CPT	Global	Descriptor	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME 3DV	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered services provided by a	8	0.037	0.030			1.73			57	10				32			15					
2nd REF	99498	ZZZ	Advance care planning including the explanation and discussion of advance directives such as	5	0.047	0.047			1.40			30					30								
SURVEY	99425	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	47	0.048	0.048	0.38	1.00	1.50	1.88	10.00	30			7	20	30	36	3696		0	0	2	10	500
REC	99425	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month		0.033	0.033			1.00			30					30								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	P	Q	R	S	T	U	V	AQ	AR	AS	AT	AU
11	**ISSUE:** Care Management Services: CCM, CCCM & PCM																									
12	**TAB:** 25																									
13							Work Per	RVW					Total	PRE-TIME		INTRA-TIME					IMMD	SURVEY EXPERIENCE				
14	Source	CPT	Global	Descriptor	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	3DW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
84																										
85							Work Per	RVW					Total	PRE-TIME		INTRA-TIME					IMMD	SURVEY EXPERIENCE				
86	Source	CPT	Global	Descriptor	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	3DW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
87	1st REF	99226	XXX	Subsequent observation care, per day, for the evaluation and management of a patient, which	8	0.048	0.036			2.00			55	10				30			15					
88	2nd REF	99091	XXX	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring)	7	0.029	0.028			1.10			40	5				30			5					
89	CURRENT CMS/OTHER	G2065	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month		0.020	0.020			0.61			30					30								
90	SURVEY	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	53	0.052	0.052	0.33	1.10	1.56	2.00	10.00	30			2	18	30	40	3696		0	0	10	60	1200
91	REC	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month		0.040	0.040			1.00			25					25								
92	XWALK	88121	ZZZ	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric		0.040	0.040			1.00			25					25								
93																										
94																										
95							Work Per	RVW					Total	PRE-TIME		INTRA-TIME					IMMD	SURVEY EXPERIENCE				
96	Source	CPT	Global	Descriptor	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	3DW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
97	1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered services provided by a	8	0.037	0.030			1.73			57	10				32			15					
98	2nd REF	99091	XXX	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring)	6	0.029	0.028			1.10			40	5				30			5					
99	SURVEY	99427	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	51	0.040	0.040	0.30	0.91	1.20	1.76	10.00	30			2	14	30	36	3696		0	0	2	20	500
100	REC	99427	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month		0.036	0.036			0.71			20					20								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
13	Summary A-Extended	**ISSUE:**	**Care Management Services: CCM, CCCM & PCM**																								
14	Society breakdown	**TAB:**	**25**		**12/21/2020 Data**																						
15	Percent							Work Per	RVW					Total	PRE-TIME		INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Vig Typical	Source	CPT	Global	Short or Long DESC	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL 3DW		MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	12%	1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered se	10	0.037	0.030			1.73			57	10				32			15					
18	11%	2nd REF	99497	XXX	Advance care planning including the explanation and discussion	9	0.039	0.033			1.50			45	5				30			10					
19		Current	99490	XXX	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care		0.041	0.041			0.61			15					15								
20	75%	ACP & AAFP	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	4	0.030	0.030	0.70	0.74	0.83	1.03	1.40	27.5			11	22	28	30	30		0	1	2	51	100
21	93%	AGS & AMDA	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	46	0.048	0.048	0.60	1.00	1.20	1.50	60.00	25			5	20	25	30	60		0	4	16	50	400
22	100%	ANA	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	10	0.054	0.054	0.75	1.03	1.21	1.85	2.00	22.5			1	16	23	30	35		12	20	30	100	240
23	50%	AOA	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	2	0.297	0.297	1.30	3.48	5.65	7.83	10.00	19			8	14	19	25	30		0	0	1	1	1
24	100%	AAHPM	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	7	0.048	0.048	1.00	1.10	1.20	1.40	1.75	25			11	20	25	28	30		0	0	50	275	800
25	80%	AAP	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	10	0.062	0.062	0.40	0.60	1.55	2.00	2.25	25			6	20	25	27	45		0	1	8	48	500
26	40%	ACRh	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	5	0.065	0.065	1.00	1.10	1.30	1.30	1.50	20			20	20	20	24	35		0	0	12	26	30
27	88%	TOTAL	99490	XXX	CCM, multi-cond's, clinical staff first 20 minutes, per cal month	84	0.048	0.048	0.40	1.00	1.20	1.52	60.00	25			1	20	25	30	60		0	1	12	50	800
28		REC	99490	XXX	**CCM, multi-cond's, clinical staff first 20 minutes, per cal month**		0.040	0.040			1.00			25					25								
29																											
30	12%	1st REF	99231	XXX	Subsequent hospital care, per day, for the evaluation and manag	9	0.054	0.038			0.76			20	5				10			5					
31	11%	2nd REF	99457	XXX	Remote physiologic monitoring treatment management services,	8	0.031	0.031			0.61			20					20								
32	11%	2nd REF	99238	XXX	Hospital discharge day management; 30 minutes or less	8	0.044	0.034			1.28			38	8				20			10					
33	CMS revised Time	CURRENT 2020	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal month		0.041	0.041			0.61			15					15								
34	CMS revised Time	CURRENT 2020	G2058	ZZZ	Chronic care management services, each additional 20 minutes of clinical sta		0.036	0.036			0.54			15					15								
35	67%	ACP & AAFP	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal mont	3	0.058	0.058	0.55	0.63	0.70	0.83	0.95	12			9	11	12	16	20		0	10	20	30	40
36	90%	AGS & AMDA	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal mont	39	0.041	0.041	0.25	0.73	0.90	1.00	20.00	22			10	20	22	30	70		0	1	10	25	500
37	100%	ANA	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal mont	10	0.043	0.043	0.20	0.79	0.98	1.08	2.00	22.5			5	20	23	25	30		0	0	5	20	25
38	0%	AOA	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal mont	1	0.500	0.500	10.00	10.00	10.00	10.00	10.00	20			20	20	20	20	20		1	1	1	1	1
39	100%	AAHPM	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal mont	7	0.045	0.045	0.60	0.75	0.90	1.15	1.30	20			5	20	20	25	44		0	0	20	155	500
40	90%	AAP	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal mont	10	0.040	0.040	0.40	0.58	0.81	1.15	1.75	20			6	10	20	30	48		0	1	4	17	500
41	100%	ACRh	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal mont	5	0.047	0.047	0.70	0.80	0.93	1.00	1.30	20			18	20	20	20	20		0	0	0	1	4
42	91%	TOTAL	99439+	ZZZ	CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal month	75	0.047	0.047	0.20	0.70	0.93	1.10	20.00	20			5	20	20	30	70		0	0	5	20	500
43		REC	99439+	ZZZ	**CCM, multi-cond's, clinical staff, each add'l 20 minutes, per cal month**		0.035	0.035			0.70			20					20								
44																											

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
13	Summary A-Extended	**ISSUE:**	**Care Management Services: CCM, CCCM & PCM**																								
14	Society breakdown	**TAB:**	**25**		**12/21/2020 Data**																						
15	Percent							Work Per	RVW					Total	PRE-TIME		INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Vig Typical	Source	CPT	Global	Short or Long DESC	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL 3DW		MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
45	26%	1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered se	14	0.037	0.030			1.73			57	10				32			15					
46	13%	2nd REF	99239	XXX	Hospital discharge day management; more than 30 minutes	7	0.045	0.035			1.90			55	10				30			15					
47	CMS revised Time	CURRENT 2020	99491	XXX	Chronic care management services, provided personally by a physician or ot		0.048	0.048			1.45			30					30								
48	100%	ACP & AAFP	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	4	0.046	0.046	0.50	1.40	1.72	1.75	1.80	37.5			14	30	38	40	40		0	2	3	12	20
49	88%	AGS & AMDA	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	26	0.057	0.057	0.85	1.67	1.85	2.01	75.00	32.5			15	30	33	40	70		0	0	5	21	250
50	100%	ANA	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	5	0.067	0.067	0.95	1.78	2.00	2.35	2.50	30			15	30	30	40	145		1	4	40	150	210
51	100%	AOA	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	2	0.250	0.250	1.50	3.63	5.75	7.88	10.00	23			16	20	23	27	30		0	6	1	1	1
52	100%	AAHPM	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	5	0.040	0.040	1.50	1.50	1.60	1.65	1.90	40			30	30	40	40	42		0	0	12	43	100
53	89%	AAP	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	9	0.042	0.042	0.71	1.40	1.73	2.00	2.70	41			30	30	41	45	50		0	4	10	12	500
54	25%	ACRh	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	4	0.053	0.053	1.10	1.33	1.58	1.80	1.95	30			21	26	30	30	30		0	0	0	3	6
55	87%	TOTAL	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month	55	0.053	0.050	0.50	1.50	1.75	2.00	75.00	35			14	30	33	41	145		0	0	5	23	500
56		REC	99491	XXX	CCM, multi-cond's, Phy/QHP, first 30 minutes, per cal month		0.045	0.045			1.50			33					33								
57																											
58	21%	1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered se	10	0.037	0.030			1.73			57	10				32			15					
59	10%	2nd REF	99498	ZZZ	Advanced Care Planning, each additional 30 minutes	5	0.047	0.047			1.40			30					30								
60	50%	ACP & AAFP	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	3	0.037	0.037	0.45	0.88	1.30	1.50	1.70	35			14	20	35	35	35		0	4	8	11	15
61	96%	AGS & AMDA	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	23	0.047	0.047	0.70	1.00	1.28	1.65	20.00	27			15	20	27	30	50		0	0	2	20	100
62	100%	ANA	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	4	0.048	0.048	1.00	1.11	1.44	1.92	2.50	30			20	28	30	31	35		0	0	2	16	56
63	100%	AOA	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	1	0.500	0.500	10.00	10.00	10.00	10.00	10.00	20			20	20	20	20	20		1	1	1	1	1
64	100%	AAHPM	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	5	0.041	0.041	1.00	1.00	1.65	2.00	2.10	40			30	33	40	40	###		0	0	6	30	60
65	89%	AAP	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	9	0.033	0.033	0.40	0.92	1.00	1.20	1.73	30			15	21	30	35	75		0	0	1	6	100
66	100%	ACRh	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	3	0.063	0.063	1.30	1.60	1.90	1.93	1.95	30			10	20	30	38	45		0	0	0	2	4
67	94%	TOTAL	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month	48	0.043	0.043	0.40	1.00	1.29	1.73	20.00	30			10	20	30	35	5280		0	0	1	15	100
68		REC	99437+	ZZZ	CCM, multi-cond's, Phy/QHP, each add'l 30 minutes, per cal month		0.033	0.033			1.00			30					30								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
13	Summary A-Extended	**ISSUE:**	**Care Management Services: CCM, CCCM & PCM**																								
14	Society breakdown	**TAB:**	**25**		**12/21/2020 Data**																						
15	Percent							Work Per	RVW					Total	PRE-TIME		INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Vig Typical	Source	CPT	Global	Short or Long DESC	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL 3DW		MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
69																											
70	21%	1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered se	12	0.037	0.030			1.73			57	10				32			15					
71	10%	2nd REF	99226	XXX	Subsequent observation care, per day, for the evaluation and ma	8	0.048	0.036			2.00			55	10				30			15					
72	CMS revised Time	CURRENT 2020	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month		0.038	0.038			1.00			26					26								
73	100%	ACP & AAFP	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	3	0.088	0.088	0.43	1.32	2.20	2.25	2.30	25			10	18	25	43	60		0	4	8	11	15
74	92%	AGS & AMDA	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	24	0.047	0.047	0.85	2.00	2.33	2.50	100.00	50			19	32	50	61	90		0	0	7	36	300
75	100%	ANA	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	4	0.089	0.089	0.95	1.81	2.23	2.39	2.50	25			1	15	25	38	60		2	6	9	18	42
76	100%	AOA	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	1	1.000	1.000	10.00	10.00	10.00	10.00	10.00	10			10	10	10	10	10		1	1	1	1	1
77	100%	AAHPM	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	6	0.045	0.045	1.00	1.34	1.79	1.96	2.80	40			15	31	40	56	70		0	0	0	100	100
78	90%	AAP	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	10	0.043	0.043	1.30	1.80	1.92	2.33	3.20	45			15	41	45	57	71		0	1	10	20	500
79	75%	ACRh	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	3	0.039	0.039	1.85	2.09	2.33	2.42	2.50	60			55	58	60	60	60		0	0	0	0	0
80	92%	TOTAL	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month	51	0.047	0.047	0.43	1.81	2.10	2.50	100.00	45			1	30	45	60	90		0	0	5	30	500
81		REC	99487	XXX	CCCM, multi-cond's, clinical staff first 60 minutes, per cal month		0.040	0.040			1.81			45					45								
82																											
83	14%	1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered se	7	0.037	0.030			1.73			57	10				32			15					
84	14%	2nd REF	99457	XXX	Remote physiologic monitoring treatment management services,	7	0.031	0.031			0.61			20					20								
85	CMS revised Time	CURRENT 2020	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal month		0.038	0.038			0.50			13					13								
86	100%	ACP & AAFP	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal mo	3	0.110	0.110	0.40	0.75	1.10	1.30	1.50	10			10	10	10	28	45		0	3	5	8	10
87	96%	AGS & AMDA	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal mo	24	0.047	0.047	0.50	1.00	1.35	1.78	20.00	28.5			15	20	29	35	60		0	0	8	29	120
88	100%	ANA	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal mo	4	0.039	0.039	1.15	1.19	1.47	1.92	2.50	37.5			10	25	38	46	50		0	1	6	11	15
89	100%	AOA	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal mo	1	0.333	0.333	10.00	10.00	10.00	10.00	10.00	30			30	30	30	30	30		1	1	1	1	1
90	100%	AAHPM	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal mo	6	0.044	0.044	0.48	0.63	1.10	1.43	1.80	25			6	14	25	35	45		0	0	0	60	75
91	90%	AAP	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal mo	10	0.038	0.038	0.40	8.00	0.96	1.00	1.75	25.5			8	19	26	30	91		0	0	3	13	200
92	100%	ACRh	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal mo	3	0.042	0.042	0.76	1.01	1.25	1.75	2.25	30			30	30	30	30	30		0	0	0	1	1
93	96%	TOTAL	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal month	51	0.040	0.040	0.40	1.00	1.20	1.70	20.00	30			6	20	30	35	91		0	0	2	15	200
94		REC	99489+	ZZZ	CCCM, multi-cond's, clinical staff, each add'l 30 minutes, per cal month		0.033	0.033			1.00			30					30								
95																											

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
13	Summary A-Extended	**ISSUE:** Care Management Services: CCM, CCCM & PCM																									
14	Society breakdown	**TAB:** 25			12/21/2020 Data																						
15	Percent							Work Per	RVW					Total	PRE-TIME		INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Vig Typical	Source	CPT	Global	Short or Long DESC	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL 3DW		MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
96	15%	1st REF	99226	XXX	Subsequent observation care, per day, for the evaluation and ma	8	0.048	0.036			2.00			55	10				30			15					
97	13%	2nd REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered se	7	0.037	0.030			1.73			57	10				32			15					
98	CMS revised Time	CURRENT 2020 G2064	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month		0.048	0.048			1.45			30					30								
99	100%	AAN	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	14	0.046	0.046	1.20	1.83	2.00	2.44	5.00	43.5			25	33	44	45	125		0	10	28	100	###
100	100%	ACP	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	2	0.050	0.050	0.40	0.73	1.05	1.38	1.70	21			7	14	21	28	35		0	2	4	6	8
101	91%	AGS & AMDA	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	11	0.058	0.058	1.00	1.33	1.75	2.00	2.25	30			15	16	30	30	45		0	0	10	16	300
102	67%	ANA	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	3	0.067	0.067	0.95	1.48	2.00	2.00	2.00	30			12	21	30	38	45		0	2	3	52	100
103	100%	AOA	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	1	0.333	0.333	10.00	10.00	10.00	10.00	10.00	30			30	30	30	30	30		1	1	1	1	1
104	75%	AAHPM	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	4	0.040	0.040	0.80	1.33	1.50	1.63	2.00	37.5			30	34	38	954	###		0	5	153	325	400
105	91%	AAP	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	11	0.045	0.045	0.92	1.35	1.56	1.72	3.00	35			25	30	35	41	45		0	3	10	18	500
106	100%	ACRh	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	7	0.049	0.049	1.00	1.25	1.70	1.85	2.45	35			20	28	35	38	42		0	0	0	1	200
107	92%	TOTAL	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month	53	0.054	0.054	0.40	1.45	1.73	2.00	10.00	32			7	30	32	42	###		0	0	10	32	###
108		REC	99424	XXX	PCM, sgl-cond, Phy/QHP, first 30 minutes, per cal month		0.045	0.045			1.45			32					32								
109																											
110	17%	1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered se	8	0.037	0.030			1.73			57	10				32			15					
111	11%	2nd REF	99498	ZZZ	Advance care planning including the explanation and discussion	5	0.047	0.047			1.40			30					30								
112	100%	AAN	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	11	0.065	0.065	0.70	1.30	1.95	2.33	3.50	30			10	30	30	40	60		0	3	10	26	500
113	50%	ACP	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	2	0.051	0.051	0.38	0.71	1.04	1.37	1.70	20.5			7	14	21	27	34		0	1	3	4	5
114	100%	AGS & AMDA	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	11	0.104	0.104	0.50	1.35	1.56	1.85	2.45	15			10	14	15	29	45		0	0	8	11	100
115	100%	ANA	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	2	0.036	0.036	1.15	1.30	1.44	1.59	1.73	40			30	35	40	45	50		0	1	1	2	2
116	100%	AOA	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	1	0.500	0.500	6.00	10.00	10.00	10.00	10.00	20			20	20	20	20	20		1	1	1	1	1
117	100%	AAHPM	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	4	0.042	0.042	1.00	1.15	1.35	1.63	2.00	32.5			30	30	33	950	###		0	3	52	150	300
118	91%	AAP	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	11	0.033	0.033	0.40	0.89	1.00	1.33	2.00	30			7	20	30	48	75		0	0	1	6	100
119	100%	ACRh	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	5	0.049	0.049	0.61	1.00	1.22	1.30	1.80	25			25	25	25	30	33		0	0	0	0	1
120	96%	TOTAL	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month	47	0.050	0.050	0.38	1.00	1.50	1.88	10.00	30			7	20	30	36	###		0	0	2	10	500
121		REC	99425+	ZZZ	PCM, sgl-cond, Phy/QHP, each add'l 30 minutes, per cal month		0.033	0.033			1.00			30					30								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
13	Summary A-Extended	**ISSUE:**	**Care Management Services: CCM, CCCM & PCM**																								
14	Society breakdown	**TAB:**	**25**		**12/21/2020 Data**																						
15	Percent							Work Per	RVW					Total	PRE-TIME		INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Vig Typical	Source	CPT	Global	Short or Long DESC	Resp	IWPUT	Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL 3DW		MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
122																											
123	15%	1st REF	99226	XXX	Subsequent observation care, per day, for the evaluation and ma	8	0.048	0.036			2.00			55	10				30			15					
124	13%	2nd REF	99091	XXX	Collection and interpretation of physiologic data (eg, ECG, blood	7	0.029	0.028			1.10			40	5				30			5					
125	CMS revised Time	CURRENT 2020 G2065	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month		0.020	0.020			0.61			30					30								
126	100%	AAN	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	14	0.043	0.043	0.61	1.71	1.89	2.08	5.00	43.5			11	30	44	60	240		0	10	48	363	###
127	100%	ACP	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	2	0.062	0.062	0.33	0.52	0.72	0.91	1.10	11.5			5	8	12	15	18		0	2	3	5	6
128	92%	AGS & AMDA	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	12	0.060	0.060	1.00	1.24	1.58	1.93	2.20	26.5			15	17	27	30	45		0	0	6	63	300
129	100%	ANA	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	2	0.179	0.179	0.95	1.21	1.48	1.74	2.00	8.25			2	5	8	12	15		0	1	1	2	2
130	100%	AOA	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	1	0.333	0.333	10.00	10.00	10.00	10.00	10.00	30			30	30	30	30	30		1	1	1	1	1
131	80%	AAHPM	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	5	0.043	0.043	0.75	1.20	1.50	2.00	2.00	35			10	20	35	40	###		0	0	25	100	300
132	91%	AAP	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	11	0.043	0.043	0.40	0.79	1.30	1.63	3.00	30			8	21	30	40	60		0	3	10	16	50
133	100%	ACRh	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	6	0.047	0.047	1.00	1.10	1.45	1.69	1.80	31			15	26	31	38	40		0	0	1	526	750
134	94%	TOTAL	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month	53	0.052	0.052	0.33	1.10	1.56	2.00	10.00	30			2	18	30	40	###		0	0	10	60	###
135		REC	99426	XXX	PCM, sgl-cond, clinical staff first 30 minutes, per cal month		0.040	0.040			1.00			30					30								
136																											
137	16%	1st REF	G0181	XXX	Physician supervision of a patient receiving medicare-covered se	8	0.037	0.030			1.73			57	10				32			15					
138	12%	2nd REF	99091	XXX	Collection and interpretation of physiologic data (eg, ECG, blood	6	0.029	0.028			1.10			40	5				30			5					
139	100%	AAN	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	13	0.051	0.051	0.61	1.25	1.77	2.00	2.50	35			9	30	35	45	90		9	30	35	45	90
140	100%	ACP	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	2	0.082	0.082	0.30	0.50	0.70	0.90	1.10	8.5			5	7	9	10	12		5	7	9	10	12
141	92%	AGS & AMDA	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	12	0.066	0.066	0.30	1.00	1.39	1.65	2.20	21			10	15	21	33	45		10	15	21	33	45
142	100%	ANA	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	3	0.250	0.250	1.20	1.23	1.25	1.49	1.73	5			2	4	5	10	15		2	4	5	10	15
143	100%	AOA	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	1	0.333	0.333	10.00	10.00	10.00	10.00	10.00	30			30	30	30	30	30		30	30	30	30	30
144	75%	AAHPM	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	4	0.054	0.054	0.50	1.25	1.75	2.08	2.30	32.5			5	24	33	950	###		5	24	33	950	###
145	91%	AAP	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	11	0.030	0.030	0.30	0.50	0.90	1.00	1.10	30			8	18	30	33	61		8	18	30	33	61
146	100%	ACRh	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	5	0.036	0.036	0.61	1.00	1.08	1.40	1.50	30			10	25	30	32	60		10	25	30	32	60
147	94%	TOTAL	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month	51	0.040	0.040	0.30	0.91	1.20	1.76	10.00	30			2	14	30	36	###		0	0	2	20	500
148		REC	99427+	ZZZ	PCM, sgl-cond, clinical staff, each add'l 30 minutes, per cal month		0.030	0.030			0.62			21					21								

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 99490, 99439, 99491, 99437, 99487, 99489,**
SPECIALTY SOCIETY(IES): _ANA, ANFP, AGS, AAN, AAP, ACP,AAHPM, AOA, ACR, ACRh
PRESENTER(S):_ Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 14, 2021
Revised 1-13-2021 during PE meeting

CPT Code	Long Descriptor	Global Period
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	XXX
99439	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored. Each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	ZZZ
99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	XXX
99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	ZZZ
99487	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the	XXX

	patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	
99489	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99490	**Typical Adult Patient** The patient is a 75-year-old man with diabetes, claudication, and mild congestive heart failure, status post myocardial infarction with mild dementia who had a peripheral arterial stent placed six weeks ago during a hospitalization for treatment of a foot ulcer. He lives with his daughter, participates in remote monitoring programs, and is being treated by two specialists in addition to his primary care physician. **Typical Child Patient** A 3-year-old former 26-week preterm child presents with bronchopulmonary dysplasia, chronic lung disease, status post tracheostomy, and cerebral palsy. Patient receives physical, occupational and speech therapy services and requires chronic care management services.
99439	**Typical Patient** During the month of chronic care management services, a 78-year-old female or 3 year old who has just received 39 minutes of clinical staff time, requires additional care management services.
99491	**Typical Adult Patient** An 83-year-old female with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program, and sees a cardiologist and neurologist. **Typical Child Patient** A 6-year-old child with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	airway disease, chronic seizure disorder, failure to thrive, and severe neurodevelopment delay. He receives home occupational, physical, and speech therapy services.
99437	**Typical Adult Patient** An 80-year-old male who has already received 59 minutes of physician or qualified healthcare professional chronic care management services during the calendar month requires additional care management services during the same calendar month. **Typical Child Patient** An 11-year-old female with past medical history of meconium aspiration at birth resulting in anoxic brain injury with cerebral palsy, asthma, allergic rhinitis and global development delay who has already received 59 minutes of physician or qualified healthcare professional chronic care management services during the calendar month and requires additional care management services during the same calendar month.
99487	**Typical Child Patient** A 6-year-old child with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airway disease, chronic seizure disorder, failure to thrive and severe neurodevelopment delay. He receives home occupational, physical and speech therapy services. Typical patient (99487) (Adult) An 83-year-old woman with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program and sees a cardiologist and neurologist.
99489	**Typical Adult Patient** A 92-year-old man living an assisted living facility with Parkinson's disease, mild dementia, depression and diabetes mellitus continues to lose weight and remains withdrawn. The patient's family resides out of state and an attendant sees the patient for 3 hours daily. The clinical staff has already spent 74 minutes in the month performing care coordination services and now spends additional time.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   RUC advisors from the surveying societies acted as an expert panel and met by video conferencing, phone, and email to develop the inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   We choose to compare to similar service for CPT codes 99439 and 99437 which have no current codes to compare to. The rest 99490, 99491, 99487, and 99489 all use current codes.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Reference Code 99458 was used as the reference code for both 99439 and 99437: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   N/A

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   From RUC database 2019 varying top percentages based on the CPT code. Internal Medicine, Family Medicine, Nurse Practitioners, Cardiology, Pediatrics, Physicians Assistant

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   After considering all the comments and questions from our pre-facilitation committee we think it may be best to focus on a few key points to clarify how the CCM codes meet the PE criterion for compelling evidence that **technology and patient and provider knowledge** has changed in recent years: We would point out that for PE we are not asking for changes to the total times to the CCCM codes 99487 and 99489. Our compelling evidence is for the CCM CPT codes. As we have all experienced in the team-based care of patients, the amount of data to review has increased dramatically in the last several years. Just 10 years ago, patient communications were mostly limited to phone, email, fax, regular mail and the occasional text. With the introduction of patient portals, the 24/7 ability to communicate with the practices has increased the # of interactions per patient. Technology has evolved to allow patients to include attachments of spreadsheets, photos and documents to review. Additionally, the evolving sophistication of

smartphones and wearables, along with a proliferation of apps have increased the amount health information access for our patients and in turn data they are sharing with their physicians/QHP. In addition to patient portals, home care agencies/pharmacies/insurances have their own portals which sometimes communicate with our own EHR, but often require separate access to address alerts and questions related to patient care. So while the traditional phone, email, fax and mail communications continue we now have patient portals, secure messaging apps, outside portals, and texts providing information for which we are responsible to review and respond.
For concrete data regarding the increase in adoption of this technology, we obtained information from Dr. Michele Thomas, CMIO of the BJC Medical Group, which is the physician component of BJC HealthCare / Washington University School of Medicine in St Louis. Tracking portal use over 4 years indicates that the number of users and logins annually has increased dramatically. In 2017, they reported just over 403,000 logins from over 44,000 users. Just 2 years later in 2019 the logins had increased by 17 fold with over 6.8 MILLION logins and individual users increased more than 6 times to 297K. Average log-in per user **more than doubled** from 9 to 22 during that same time period. This translates to dramatically increased data entry and information to review for each patient.

2017 - 403,631 logins; 44,434 users
2018 - 3,198,251 logins; 182,000 users
2019 - 6,845,781 logins; 297,963 users
2020 - 13,397,634 logins; 498,931 users

This data is consistent with what I and the other presenters have seen in our practices. Some examples of the information shared through portals and other electronic means of communication:

- Case managers, family members, caregivers or patients submit information related to organizational chaos in the home, financial barriers to care, needs for DME, medication confusion, new or previously unrecognized cognitive issues.
- We have more data to review through this technology-
    - Interoperable medical records provide us with much more data to review. In the past, we simply did not have this data.
    - Through the portal, patients/proxies now have easy access to review their labs, studies, and even visit notes. Questions related to something written in a note or values slightly out of the reported range require response- from incidental nodules/cysts on CT scans, insignificant laboratory results, and consultations that were not even ordered by us still require a response and may impact care plan.
- Use monitoring apps with health information obtained via wearables, external devices and patient report– some are useful for care management, but all require response and coordination when presented has increased the work of the clinical team/staff to

organize, interpret and manage (these are data, that would NOT meet the criteria for reporting of the remote monitoring CPT codes) For example, we are now receiving data re:

Cardiac monitoring apps- patient sending ekgs, information on rhythms like afib
Genetic Testing- 23&Me, Ancestory
Diabetes self-management- home glucose monitoring
Mental Health- review of PHQ9
Monitoring of respiratory status (pulse ox) and sleep patterns.

In SUMMARY

- More complex medical conditions can now be managed while the patient is at home instead of during face-to-face services. These CCM and CCCM codes allow us to help keep patients at home and avert disease exacerbations and unnecessary ER/Hospital admissions. This shift occurred before COVID-19, was accelerated during, and will continue after.
- The increased portal use and the rapid evolution of sophisticated tools such as remote monitoring apps, self-management apps, ability for patients to transmit both simple and complex data (e.g., high resolution photographs) in real time has increased the ability to care for patients at home but with an unprecedented about of information to review and increased work for physician and staff.

Therefore, we believe the technology and data are what is easiest to understand for why we believe we meet compelling evidence. Our staff are just are not able to complete all task in the historical times.

Therefore, the panel believes that compelling evidence for PE for CCM services has been met.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 99490, 99439, 99491, 99437, 99487, 99489,**

SPECIALTY SOCIETY(IES): _ANA, ANFP, AGS, AAN, AAP, ACP,AAHPM, AOA, ACR, ACRh

PRESENTER(S):_ Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

None

b. Service period (includes pre, intra and post):

Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;

Communication with home health agencies, other healthcare providers, and other community services utilized by the patient;

Collection of health outcomes data and registry documents;

Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living

Assessment and support for treatment regimen adherence and medication management;

Identification of available community and health resources;

Facilitating access to care and services needed by the patient and/or family;

Management of care transitions not reported as part of the transitional care management (99495, 99496)

Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M, noted above;

Development, communication, and maintenance of ava comprehensive care plan.

When above are personally performed by physician or QHP, CPT 99491, 99437 the below are the clinical staff activities in addition to the 30 minutes by the physician or QHP:

Calls in or email prescription(s)

Communicate with the patient or caregiver if the physician/QHP is unavailable

Receive, review and send tests results and other clinical information to and from other care givers

Schedule appointment(s) with other healthcare providers and outside agencies

Take call(s) from patient or contact patient when physician/QHP is available for call

c. Post-service period:

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 99490, 99439, 99491, 99437, 99487, 99489,**

SPECIALTY SOCIETY(IES): _ANA, ANFP, AGS, AAN, AAP, ACP,AAHPM, AOA, ACR, ACRh

PRESENTER(S):_ Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

None

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

These are not directly related to physician work:
Five minutes per month in relaying/communicating patient messages,

Five minutes in communication with patient and/or pharmacy for prescription refills, prior authorizations or clarifications (assisting physician with paperwork for DME may be included here, or separately)

Five minutes for coordination with outside agencies or other providers (i.e. Obtaining referral forms, tracking down documentation of care received outside the primary care office or tracking down results on tests ordered by provider other that the PCP

Five minutes scheduling appointments and taking calls from patient or contacting patient when physician/QHP is available.

For each code, final approved time for the individual code, divide the approved total time by 4 equally for the above, the above is an example of 20 minutes broken up.

Total 25 minutes for 99490 and 99439, 18 minutes for 99491, 99437 60 minutes for 99487 and 30 minutes for 99498.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 99490, 99439, 99491, 99437, 99487, 99489,**
SPECIALTY SOCIETY(IES): _ANA, ANFP, AGS, AAN, AAP, ACP,AAHPM, AOA, ACR, ACRh
PRESENTER(S):_ Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 99490, 99439, 99491, 99437, 99487, 99489,**

SPECIALTY SOCIETY(IES): ANA, ANFP, AGS, AAN, AAP, ACP,AAHPM, AOA, ACR, ACRh

PRESENTER(S): Megan Adamson, MD, Audrey Chun, MD, Chuck Crecelius, MD, PhD, CMD, Tanvir Hussain, MD, MBA, MHS, MSc, FACP, Steven Krug, MD, FAAP, Phillip E. Rodgers, MD, FAAHPM, Joseph Schlecht, DO, Fredrica Smith, MD, Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

Compelling Evidence was met for CCM services. **Final approved times CA021** Total 25 minutes for 99490, 99439, 18 minutes for 99491, 99437, 60 minutes for 99487 and 30 minutes for 99498. This was considering a 25% increase from the current times for clinical staff. CA021 We reduced code 99490 from 30 minutes to 25 minutes We reduced code 99439 from from 30 minutes to 25 minutes We reduced code 99491 from 20 minutes to 18 minutes We reduced code 99437 from 20 minutes to 18 minutes

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 99424, 99425, 99426, 99427**

SPECIALTY SOCIETY(IES): AAN, ANA, ACP, AGS, AOA, AAHPM, AAP, ACRh, AMDA,

PRESENTER(S): Phillip E. Rodgers, MD FAAHPM; Marianna Spanaki, MD, PhD, FAAN; Steven Krug, MD, FAAP; Tanvir Hussain, MD, MBA, MHS, MSc, FACP; Fredrica Smith, MD; Audrey Chun, MD; Charles Crecelius, MD, PhD, CMD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Joseph Schlecht, DO

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 14, 2021
Revised 1-13-2021

CPT Code	Long Descriptor	Global Period
99424	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death; the condition requires development, monitoring, or revision of disease-specific care plan; the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to the comorbidities; ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally be a physician or other qualified health care professional, per calendar month	XXX
99425	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death; the condition requires development, monitoring, or revision of disease-specific care plan; the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities; ongoing communication and care coordination between relevant practitioners furnishing care; Additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	ZZZ
99426	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death; the condition requires development, monitoring, or revision of disease-specific care plan; the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to the comorbidities; ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	XXX
99427	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death; the condition requires development, monitoring, or revision of disease-specific care plan; the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to the comorbidities; ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes of clinical staff time directed by a	ZZZ

	physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99424	A patient with a single complex chronic condition that places the patient at significant risk of decompensation.
99425	A patient with a single complex chronic condition that places the patient at significant risk of decompensation.
99426	A patient with a single complex chronic condition that places the patient at significant risk of decompensation.
99427	A patient with a single complex chronic condition that places the patient at significant risk of decompensation.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   RUC advisors from the surveying societies acted as an expert panel and met by email to develop the inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   We choose to compare to similar service with varying time as the reference code in CPT code 99457 and CPT code 99458 but also included the current G code for codes 99424, 99425, 99426, 99427.

   99457 was used as the reference code for 99424 and 99426: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

   99458 was used as the reference code for both 99425 and 99427: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

   G2064 for 99424: Comprehensive care management services for a single high-risk disease, e.g. principle care management of at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent

adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

G2065 for 99426: Comprehensive care management services for a single high-risk disease, e.g. principle care management of at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   N/A

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   There is no utilization data for G2064 or G2065 and therefore no previous utilization for new codes 99424, 99425, 99426, 99427

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

None

   b. Service period (includes pre, intra and post):

Establishing, implementing, revising, or monitoring the care plan

Coordinating the care of other professionals and agencies

Educating the patient or caregiver about the patients condition, care plan, and prognosis

When above are personally performed by physician or QHP, CPT 99424 and 99425 the below are the clinical staff activities in addition to the 30 minutes by the physician or QHP:

Calls in or email prescription(s)

Communicate with the patient or caregiver if the physician/QHP is unavailable

Receive, review and send tests results and other clinical information to and from other care givers

Schedule appointment(s) with other healthcare providers and outside agencies

Take call(s) from patient or contact patient when physician/QHP is available for call

   c. Post-service period:

None

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

These are not directly related to physician work: for each code divide equally the total time by 4 to get the time for each of the granular activity.
7.5 Minutes for Establishing, implementing, revising, or monitoring the care plan
X Minutes for Coordinating the care of other professionals and agencies, scheduling appointments
7.5 Minutes for Communication with patient and/or pharmacy for prescription refills, prior authorizations or clarifications

7.5 Minutes for Educating the patient or caregiver about the patients condition, care plan and prognosis

Total 25 minutes for 99424 and 99425, 15 minutes for 99426, 99427 30 minutes. Example above is for 30 total minutes. 3.75 minutes for each above for 15 total minutes.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
N/A

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused

with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

CA021
We reduced code 99424 from 20 minutes to 15 minutes
We reduced code 99425 from 20 minutes to 15 minutes
We reduced code 99426 from 35 minutes to 30 minutes

	A	B	D	E	F	K	L	M	N	O	P
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		REFERENCE CODE	
2						CPT Code 99490		CPT Code 99490		CPT Code 99458	
3		*RUC Collaboration Website*				Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other QHP, per calendar month, with the		Chronic care management services, with the following required elements: • multiple (two or more) chronic conditions expected to		Remote physiologic monitoring treatment management services, clinical staff/physician/other QHP time	
4	Clinical Activity Code	~~Meeting Date: Jan 13, 2021~~ Revision Date (if applicable): Jan 13-2021 Tab: 25 Specialty: ANA, AAFP, AGS, AAN, AAP, ~~ACR, AAHPM, ACA, ACPM, AMDA~~	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute						
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				XXX		XXX		ZZZ	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 7.40	$ -	$ 9.25	$ -	$ 7.40	$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	20.0	0.0	25.0	0.0	20.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	20.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	0.0	25.0	0.0	10.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	10.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				$ 7.40	$ -	$ 9.25	$ -	$ 7.40	$ -
13		PRE-SERVICE PERIOD									
14		Start: Following visit when decision for surgery/procedure made									
15	CA001	~~Complete pre-service diagnostic and referral~~	L037D	RN/LPN/MTA	0.37						
16	CA002	~~Coordinate pre-surgery services (including test results)~~	L037D	RN/LPN/MTA	0.37	20					
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37						
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37						
19	CA005	~~Complete pre-procedure phone calls and prioritize~~	L037D	RN/LPN/MTA	0.37						
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37						
21	CA007	~~Review patient clinical extant information and pending~~	L037D	RN/LPN/MTA	0.37						
22	CA008	~~Perform regulatory mandated quality assurance activity (pre-service)~~	L037D	RN/LPN/MTA	0.37						
29		End: When patient enters office/facility for surgery/procedure									
30		SERVICE PERIOD									
31		Start: When patient enters office/facility for surgery/procedure:									
32		Pre-Service (of service period)									
33	CA009	~~Greet patient, provide gowning, ensure appropriate medical records are available~~	L037D	RN/LPN/MTA	0.37						
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37						
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37						
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37						
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37						
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37						
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37						
40	CA016	~~Prepare, set-up and start IV, initial positioning and monitoring of patient~~	L037D	RN/LPN/MTA	0.37						
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37						
48		Intra-service (of service period)									
49	CA018	~~Assist physician or other qualified healthcare~~	L037D	RN/LPN/MTA	0.37						
50	CA019	~~Assist physician or other qualified healthcare~~	L037D	RN/LPN/MTA	0.37						
51	CA020	~~Assist physician or other qualified healthcare~~	L037D	RN/LPN/MTA	0.37						
52	CA021	~~Perform procedure/service**NOT directly~~	L037D	RN/LPN/MTA	0.37			25		10	
59	CA021	~~Perform procedure/service**NOT directly related to physician work time~~	L051A	RN	0.51						
60		Post-Service (of service period)									
61	CA022	~~Monitor patient following procedure/service,~~	L037D	RN/LPN/MTA	0.37						
62	CA023	~~Monitor patient following procedure/service, as multitasking~~	L037D	RN/LPN/MTA	0.37						
63	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37						
64	CA025	Clean scope	L037D	RN/LPN/MTA	0.37						
65	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37						
66	CA027	~~Complete post-procedure diagnostic forms,~~	L037D	RN/LPN/MTA	0.37						
67	CA028	~~Review/read post-procedure x-ray, lab and pathology reports~~	L037D	RN/LPN/MTA	0.37						
68	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37						
69	CA030	~~Technologist QC's images in PACS, checking acquisitions for completeness~~	L037D	RN/LPN/MTA	0.37						
70	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37						
71	CA032	~~Scan exam documents into PACS. Complete~~	L037D	RN/LPN/MTA	0.37						
72	CA033	~~Perform regulatory mandated quality~~	L037D	RN/LPN/MTA	0.37						
73	CA034	~~Document procedure (non-PACS) (e.g.~~	L037D	RN/LPN/MTA	0.37						
74	CA035	~~Review home care instructions, use EEC file~~	L051A	RN	0.51						
75	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a		n/a		n/a	
82											
83		POST-SERVICE PERIOD									
84		Start: Patient leaves office/facility									
85	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37					10	
86	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37						
87		~~Office visits: List Number and Level of Office Visit~~	MINUTES			# visits	# visits	# visits	# visits	# visits	# visits
88		99211 16 minutes	16								
89		99212 27 minutes	27								
90		99213 36 minutes	36								
91		99214 53 minutes	53								
92		99215 63 minutes	63								
93	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	0.0	0.0
100		End: with last office visit before end of									
101	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT							
102		TOTAL COST OF SUPPLY QUANTITY x PRICE				$ -	$ -	$ -	$ -	$ -	$ -
111	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute						
112		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				$ -	$ -	$ -	$ -	$ -	$ -
120											

	A	B	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD
1	RUC Practice Expense Spreadsheet		RECOMMENDED		CURRENT		RECOMMENDED		REFERENCE CODE		RECOMMENDED		CURRENT		RECOMMENDED	
2			CPT Code 99439		CPT Code 99491		CPT Code 99491		CPT Code 99458		CPT Code 99437		CPT Code 99487		CPT Code 99487	
3		*RUC Collaboration Website*	each additional 20 minutes of		Chronic care management		Chronic care management				each additional 30 minutes		Complex chronic care		Complex chronic care	
4	Clinical Activity Code	Meeting Date: Jan 13, 2021 Revision Date (if applicable): Jan 13-2021 Tab: 25 Specialty: ANA, AAFP, AGS, AAN, AAP,	clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List		services, provided personally by a physician or other QHP, at least 30 minutes of physician or other QHP time,		services with the following required elements: •multiple (two or more) chronic conditions expected to last at		Remote physiologic monitoring treatment management services, clinical staff/physician/other		by a physician or other qualified health care professional, per calendar month (List separately in		management services, with the following required elements: multiple (two or more) chronic conditions		management services, with the following required elements: •multiple (two or more)	
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	ZZZ		XXX		XXX	XXX	ZZZ		ZZZ		XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 9.25	$ -	$ 5.55	$ 5.55	$ 6.66	$ -	$ 7.40	$ -	$ 6.66	$ -	$ 30.60	$ -	$ 30.60	$ -
8		TOTAL CLINICAL STAFF TIME	25.0	0.0	15.0	15.0	18.0	0.0	20.0	0.0	18.0	0.0	60.0	0.0	60.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	25.0	0.0	15.0	15.0	18.0	0.0	10.0	0.0	18.0	0.0	60.0	0.0	60.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ 9.25	$ -	$ 5.55	$ 5.55	$ 6.66	$ -	$ 7.40	$ -	$ 6.66	$ -	$ 30.60	$ -	$ 30.60	$ -
13		PRE-SERVICE PERIOD														
14		Start: Following visit when decision for sur														
15	CA001	Complete pre-service diagnostic and referral														
16	CA002	Coordinate pre-surgery services (including														
17	CA003	Schedule space and equipment in facility														
18	CA004	Provide pre-service education/obtain consent														
19	CA005	Complete pre-procedure phone calls and														
20	CA006	Confirm availability of prior images/studies														
21	CA007	Review patient clinical extant information and														
22	CA008	Perform regulatory mandated quality														
29		End: When patient enters office/facility for s														
30		SERVICE PERIOD														
31		Start: When patient enters office/facility for														
32		Pre-Service (of service period)														
33	CA009	Greet patient, provide gowning, ensure														
34	CA010	Obtain vital signs														
35	CA011	Provide education/obtain consent														
36	CA012	Review requisition, assess for special needs														
37	CA013	Prepare room, equipment and supplies														
38	CA014	Confirm order, protocol exam														
39	CA015	Setup scope (nonfacility setting only)														
40	CA016	Prepare, set-up and start IV, initial positioning														
41	CA017	Sedate/apply anesthesia														
48		Intra-service (of service period)														
49	CA018	Assist physician or other qualified healthcare														
50	CA019	Assist physician or other qualified healthcare														
51	CA020	Assist physician or other qualified healthcare														
52	CA021	Perform procedure/service--NOT directly	25		15	15	18		10		18					
59	CA021	Perform procedure/service--NOT directly													60	
60		Post-Service (of service period)														
61	CA022	Monitor patient following procedure/service,														
62	CA023	Monitor patient following procedure/service,														
63	CA024	Clean room/equipment by clinical staff														
64	CA025	Clean scope														
65	CA026	Clean surgical instrument package														
66	CA027	Complete post-procedure diagnostic forms,														
67	CA028	Review/read post-procedure X-ray, lab and														
68	CA029	Check dressings, catheters, wounds														
69	CA030	Technologist QC's images in PACS, checking														
70	CA031	Review examination with interpreting MD/DO														
71	CA032	Scan exam documents into PACS. Complete														
72	CA033	Perform regulatory mandated quality														
73	CA034	Document procedure (non-PACS) (e.g.														
74	CA035	Review home care instructions, coordinate											60			
75	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a		n/a		n/a	
82																
83		POST-SERVICE PERIOD														
84		Start: Patient leaves office/facility														
85	CA037	Conduct patient communications							10							
86	CA038	Coordinate post-procedure services														
87		*Office visits: List Number and Level of*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
88		99211 16 minutes														
89		99212 27 minutes														
90		99213 36 minutes														
91		99214 53 minutes														
92		99215 63 minutes														
93	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
100		End: with last office visit before end of														
101	Supply Code	MEDICAL SUPPLIES														
102		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
111	Equipment Code	EQUIPMENT														
112		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
120																

	A	B	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED		REFERENCE CODE		CURRENT		RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2			CPT Code 99489		CPT Code 99489		CPT Code 99457		CPT Code G2064		CPT Code 99424		CPT Code 99458		CPT Code 99425	
3		*RUC Collaboration Website*	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions		each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar		Remote physiologic monitoring treatment management services, clinical staff/physician/other		Comprehensive care mangagment services for a single high-risk disease, e.g. principle care management, at least 30 minutes of		Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic		Remote physiologic monitoring treatment management services, clinical staff/physician/other		Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition	
4	Clinical Activity Code	**Meeting Date: Jan 13, 2021** **Revision Date (if applicable): Jan 13-2021** **Tab: 25** **Specialty: ANA, AAFP, AGS, AAN, AAP, ACP, AAHPM, ACA, ACPM, AMDA**														
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	ZZZ		ZZZ		XXX		XXX		XXX		ZZZ		ZZZ	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	$ 15.30	$ -	$ 15.30	$ -	$ 14.80	$ -	$ 11.10	$ -	$ 5.55	$ -	$ 7.40	$ -	$ 5.55	$ -
8		**TOTAL CLINICAL STAFF TIME**	30.0	0.0	30.0	0.0	40.0	0.0	30.0	0.0	15.0	0.0	20.0	0.0	15.0	0.0
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	0.0	0.0	0.0	0.0	0.0	0.0	30.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	30.0	0.0	30.0	0.0	10.0	0.0	0.0	0.0	15.0	0.0	10.0	0.0	15.0	0.0
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	0.0	0.0	0.0	0.0	30.0	0.0	0.0	0.0	0.0	0.0	10.0	0.0	0.0	0.0
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	$ 15.30	$ -	$ 15.30	$ -	$ 14.80	$ -	$ 11.10	$ -	$ 5.55	$ -	$ 7.40	$ -	$ 5.55	$ -
13		**PRE-SERVICE PERIOD**														
14		**Start: Following visit when decision for sur**														
15	CA001	Complete pre-service diagnostic and referral														
16	CA002	Coordinate pre-surgery services (including test results)							30							
17	CA003	Schedule space and equipment in facility														
18	CA004	Provide pre-service education/obtain consent														
19	CA005	Complete pre-procedure phone calls and prescriptions														
20	CA006	Confirm availability of prior images/studies														
21	CA007	Review patient clinical extant information and pending regulatory mandated quality														
22	CA008	Perform regulatory mandated quality assurance activity (qcs, service)														
29		**End: When patient enters office/facility for s**														
30		**SERVICE PERIOD**														
31		**Start: When patient enters office/facility for**														
32		**Pre-Service (of service period)**														
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available														
34	CA010	Obtain vital signs														
35	CA011	Provide education/obtain consent														
36	CA012	Review requisition, assess for special needs														
37	CA013	Prepare room, equipment and supplies														
38	CA014	Confirm order, protocol exam														
39	CA015	Setup scope (nonfacility setting only)														
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient														
41	CA017	Sedate/apply anesthesia														
48		**Intra-service (of service period)**														
49	CA018	Assist physician or other qualified healthcare														
50	CA019	Assist physician or other qualified healthcare														
51	CA020	Assist physician or other qualified healthcare														
52	CA021	Perform procedure/service--NOT directly					10				15		10		15	
59	CA021	Perform procedure/service--NOT directly			30											
60		**Post-Service (of service period)**														
61	CA022	Monitor patient following procedure/service,														
62	CA023	Monitor patient following procedure/service,														
63	CA024	Clean room/equipment by clinical staff														
64	CA025	Clean scope														
65	CA026	Clean surgical instrument package														
66	CA027	Complete post-procedure diagnostic forms,														
67	CA028	Review/read post-procedure x-ray, lab and pathology reports														
68	CA029	Check dressings, catheters, wounds														
69	CA030	Technologist QC's images in PACS, checking														
70	CA031	Review examination with interpreting MD/DO														
71	CA032	Scan exam documents into PACS. Complete														
72	CA033	Perform regulatory mandated quality														
73	CA034	Document procedure (non-PACS) (e.g.														
74	CA035	Review home care instructions, coordinate	30													
75	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a		n/a		n/a	
82																
83		**POST-SERVICE PERIOD**														
84		**Start: Patient leaves office/facility**														
85	CA037	Conduct patient communications					30						10			
86	CA038	Coordinate post-procedure services														
87		***Office visits: List Number and Level of***	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
88		99211 16 minutes														
89		99212 27 minutes														
90		99213 36 minutes														
91		99214 53 minutes														
92		99215 63 minutes														
93	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
100		**End: with last office visit before end of**														
101	Supply Code	**MEDICAL SUPPLIES**														
102		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
111	Equipment Code	**EQUIPMENT**														
112		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
120																

	A	B	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB
1	RUC Practice Expense Spreadsheet		REFERENCE CODE		CURRENT		RECOMMENDED		REFERENCE CODE		RECOMMENDED	
2			CPT Code 99457		CPT Code G2065		CPT Code 99426		CPT Code 99458		CPT Code 99427	
3		*RUC Collaboration Website*										
4	Clinical Activity Code	~~Meeting Date: Jan 13, 2021~~ Revision Date (if applicable): Jan 13-2021 Tab: 25 Specialty: ANA, AAFP, AGS, AAN, AAP, ~~ACR, AAURM, ACA, ACPM, AMDA~~	Remote physiologic monitoring treatment management services, clinical staff/physician/other		Comprehensive care mangagment services for a single high-risk disease, e.g. principle care management, at least 30 minutes of clinical		Principal care management services, for a single high-risk disease, with the following elements; one complex condition expected to last at		Remote physiologic monitoring treatment management services, clinical staff/physician/other QHP time		Principal care management services, for a single high-risk disease, with the following elements; one complex condition expected to last at	
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX		XXX	XXX	XXX		ZZZ		ZZZ	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 14.80	$ -	$ 5.55	$ 5.55	$ 11.10	$ -	$ 7.40	$ -	$ 11.10	$ -
8		TOTAL CLINICAL STAFF TIME	40.0	0.0	15.0	15.0	30.0	0.0	20.0	0.0	30.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	10.0	0.0	15.0	15.0	30.0	0.0	10.0	0.0	30.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	30.0	0.0	0.0	0.0	0.0	0.0	10.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ 14.80	$ -	$ 5.55	$ 5.55	$ 11.10	$ -	$ 7.40	$ -	$ 11.10	$ -
13		PRE-SERVICE PERIOD										
14		Start: Following visit when decision for sur										
15	CA001	~~Complete pre-service diagnostic and referral~~										
16	CA002	~~Coordinate pre-surgery services (including test results)~~										
17	CA003	Schedule space and equipment in facility										
18	CA004	Provide pre-service education/obtain consent										
19	CA005	~~Complete pre-procedure phone calls and prescriptions~~										
20	CA006	Confirm availability of prior images/studies										
21	CA007	~~Review patient clinical extant information and pending radiology~~										
22	CA008	~~Perform regulatory mandated quality assurance activity (qas service)~~										
29		End: When patient enters office/facility for s										
30		SERVICE PERIOD										
31		Start: When patient enters office/facility for										
32		Pre-Service (of service period)										
33	CA009	~~Greet patient, provide gowning, ensure appropriate medical records are available~~										
34	CA010	Obtain vital signs										
35	CA011	Provide education/obtain consent										
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies										
38	CA014	Confirm order, protocol exam										
39	CA015	Setup scope (nonfacility setting only)										
40	CA016	~~Prepare, set-up and start IV, initial positioning and monitoring of patient~~										
41	CA017	Sedate/apply anesthesia										
48		Intra-service (of service period)										
49	CA018	~~Assist physician or other qualified healthcare~~										
50	CA019	~~Assist physician or other qualified healthcare~~										
51	CA020	~~Assist physician or other qualified healthcare~~										
52	CA021	~~Perform procedure/service--NOT directly~~	10		15	15	30		10		30	
59	CA021	~~Perform procedure/service--NOT directly~~										
60		Post-Service (of service period)										
61	CA022	~~Monitor patient following procedure/service, monitor patient following procedure/service, qa multitasking~~										
62	CA023											
63	CA024	Clean room/equipment by clinical staff										
64	CA025	Clean scope										
65	CA026	Clean surgical instrument package										
66	CA027	~~Complete post-procedure diagnostic forms, Review/read post-procedure X-ray, lab and~~										
67	CA028	~~pathology reports~~										
68	CA029	Check dressings, catheters, wounds										
69	CA030	~~Technologist QC's images in PACS, checking acquisition, performance and~~										
70	CA031	Review examination with interpreting MD/DO										
71	CA032	~~Scan exam documents into PACS. Complete in RIS~~										
72	CA033	~~Perform regulatory mandated quality assurance activity (qas service)~~										
73	CA034	~~Document procedure (non-PACS) (e.g. mendated specific restrictions, EEG file~~										
74	CA035	~~Review home care instructions, coordinate visits/prescriptions~~										
75	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a	
82												
83		POST-SERVICE PERIOD										
84		Start: Patient leaves office/facility										
85	CA037	Conduct patient communications	30						10			
86	CA038	Coordinate post-procedure services										
87		~~Office visits: List Number and Level of Office Visit~~	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
88		99211 16 minutes										
89		99212 27 minutes										
90		99213 36 minutes										
91		99214 53 minutes										
92		99215 63 minutes										
93	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
100		End: with last office visit before end of										
101	Supply Code	MEDICAL SUPPLIES										
102		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
111	Equipment Code	EQUIPMENT										
112		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
120												

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2020

Chronic Care Management Services – Tab 20

In September 2019, the CPT Editorial Panel revised CPT code 99490 to describe the first 20 minutes of clinical staff time and created a new add-on code to describe each additional 20 minutes of clinical staff time for chronic care management (CCM) services. The Panel also revised codes 99487 and 99489 to eliminate the requirement to establish a care plan and revised the chronic care management services guidelines.

During the process of the societies preparing to survey, CMS published its Final Rule for CY2020, which included the creation of several new care management HCPCS codes. These included two codes for principal care management and code G2058, which has a descriptor identical to that of 99439. When these codes were released, the specialty societies decided to submit a code change proposal to CPT for the May 2020 meeting. This proposal would establish new principal care management codes, like those in the Final Rule. Because these new codes would potentially be part of the CCM family, the entire CCM family would need to be surveyed after the codes were approved by CPT. Specifically, assuming the new principal care management codes are approved at the May 2020 CPT meeting, the entire CCM family will need to be surveyed for the October 2020 RUC meeting. Therefore, if the specialty societies surveyed the CCM family for the January 2020 RUC meeting because of new code 99439, the exact same family of codes would need to be surveyed again for the October 2020 RUC meeting.

Since CMS had already established payment for the new codes for CY 2020 (including G2058), the specialty societies met with the Research Subcommittee and requested to make a presentation to the RUC requesting a temporary crosswalk to value 99439 on an interim basis for 2021 before it is surveyed in 2020 as part of the 2022 CPT and Medicare Physician Payment Schedule. The specialty societies also requested to recommend maintaining the current value of the existing CCM codes until the entire family is surveyed later in 2020.

99439 ***Chronic care management services, with the following required elements:***

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

each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC reviewed the recommended interim crosswalk of 0.54 work RVUs and 15 minutes intra-service time for CPT code 99439. The RUC agreed with the specialty societies to crosswalk the work value and time for CPT code 99439 to CPT code 11107 *Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)* (work RVU = 0.54 and 15 minutes intra-service time). The specialty societies also indicated CPT code 96171 *Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)* (work RVU = 0.54 and 15 minutes intra-service time), which the RUC agreed is also an appropriate interim crosswalk for the physician work and time required to perform 99439. The RUC notes that the recommended 15 minutes of intra-service and the work RVU are the same as that of G2058 *Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)* (work RVU = 0.54 and 15 minutes intra-service time) as assigned by CMS. **The RUC recommends an interim work RVU of 0.54 for CPT code 99439.**

Practice Expense

The RUC recommends crosswalking the clinical staff time of 20 minutes CA021 *Perform procedure/service—NOT directly related to physician work time* L037D *RN/LPN/MTA* to CPT code 99490 *Chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.* **The RUC recommends the direct practice expense inputs as submitted by the specialty society for 99439. The RUC affirmed the direct practice expense inputs for 99490, 99491, 99487 and 99489.**

Refer to CPT

The specialty societies are developing a CPT coding change application (CCA) to establish two principal care management codes for the May 2020 CPT Editorial Panel meeting. CPT codes 99490, 99439, 99491, 99487 and 99489 will be resurveyed as part of this family of services.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Prolonged Services** **Prolonged Service Without Direct Patient Contact** Do not report 99358, 99359 for time ~~*spent*~~ *without direct patient contact reported* in *other services such as* care plan oversight services (99339, 99340, 99374-99380), *chronic care management by a physician or other qualified health care profession (99491),* home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), *interprofessional telephone/internet/electronic health record consultations (99446-99452)* or *online digital evaluation and management services* (*99421, 99422, 99423*).				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

99358 ***Prolonged evaluation and management service*** *before and/or after direct patient care; first hour*

99359 *each additional 30 minutes (List separately in addition to code for prolonged procedure)*

(Use 99359 in conjunction with 99358)

(Do not report 99358, 99359 on the same date of service as 99417)

~~(Do not report 99358, 99359 during the same month with 99484, 99487-99489, 99490, 99491, 99492, 99493, 99494)~~

(Do not report 99358, 99359 when performed during the same service time of codes 99495 or 99496, if reporting 99495 or 99496)

Non-Face-to-Face Services
Digitally Stored Data Services/Remote Physiologic Monitoring

Codes 99453 and 99454 are used to report remote…

Code 99091 should be reported no more than once…

If the services described by 99091…

Do not report 99091 for time in the same calendar month ~~as~~ when used to meet the criteria for care plan oversight services (99374, 99375, 99377, 99378, 99379, 99380), home, domiciliary, or rest home care plan oversight services (99339, 99340), ~~and~~ remote physiologic monitoring services (99457), or personally performed chronic care management (99491). Do not report 99091 if other more specific codes exist (eg, 93227, 93272 for cardiographic services; 95250 for continuous glucose monitoring). Do not report 99091 for transfer and interpretation of data from hospital or clinical laboratory computers.

Code 99453 is reported for each episode…

#99091 *Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days*

(Do not report 99091 in conjunction with 99457)

(Do not report 99091 ~~if it occurs within 30 days of~~ for time in a calendar month when used to meet the criteria for 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99457, 99491)

●*99473* *Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration*

(Do not report 99473 more than once per device)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(For ambulatory blood pressure monitoring, see 93784, 93786, 93788, 93790)

●*99474* *separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient*

(Do not report 99473, 99474 in the same calendar month as 93784, 93786, 93788, 93790, 99091, 99453, 99454, 99457, 99487, 99489, 99490, 99491, 99439*)*

(Do not report 99474 more than once per calendar month)

Remote Physiologic Monitoring Treatment Management Services

Remote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan. To report remote physiological monitoring, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. *Do not u*se 99457, *99458* for *time that can be* report*ed using* more specific *monitoring services. (eg, for the patient that requires reevaluation of medication regimen and/or changes in treatment).* Code*s* 99457*, 99458* may be reported during the same service period as chronic care management services (99487, 99489, 99490, 99491, 99439), transitional care management services (99495, 99496), and behavioral health integration services (99484, 99492, 99493, 99494). *however*, time spent performing these services should remain separate and no time should be counted toward the required time for both services in a single month. Code*s* 99457*, 99458* require a live, interactive communication with the patient/caregiver. *For the first 20 minutes and 20 minutes or more* of clinical staff/physician/other qualified health care professional time in a calendar month *report 99457, and report 99458 for each additional 20 minutes. Do not report services of less than 20 minutes*. Report 99457 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month.

Do not count any time on a day when the physician or other qualified health care professional reports an E/M service (office or other outpatient services 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, inpatient services 99221, 99222, 99223, 99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255). Do not count any time related to other reported services (eg, 93290, 93793, 99291, 99292).

Care Management Services

Care management services are management and support services...

A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

~~practice will be directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.~~

A comprehensive plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation. It is intended to provide a simple and concise overview of the patient and be a useful resource for patients, caregivers, and providers.

A typical plan of care is not limited to, but may include:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive assessment
- Functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and other healthcare professionals and providers
- Summary of advance directives

The above elements are intended to be a guide for creating a meaningful plan of care rather than a strict set of requirements, so should be addressed only as appropriate for the individual.

The plan of care should include specific and achievable goals for each condition and relevant to the patient's well-being and lifestyle. When possible, the treatment goals should also be measurable and time bound. The plan should be updated periodically based on status or goals changes. The entire care plan should be reviewed at least annually.

An electronic and/or printed plan of care must be documented and shared with the patient and/or caregiver.

Codes 99487, 99489, 99490, 99491 are reported only once per calendar month and 99439 is reported no more than twice per calendar month. Codes 99487, 99489, 99490, 99491, 99439 may only be reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

For 99487, 99489, 99490, 99439, the face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals, and agencies; creating, revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month. Only the time of the clinical staff of the reporting professional is counted. Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient. For 99491, only count the time personally spent by the physician or other qualified health care professional. Do not count any of the clinical staff time spent on the day of an initiating visit (the creation of the care plan, initial explanation to the patient and/or caregiver, and obtaining consent).

Care management activities performed by clinical staff, or personally by the physician or other qualified health care professional, typically include:

- *communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;*
- *communication with home health agencies and other community services utilized by the patient;*
- *collection of health outcomes data and registry documentation;*
- *patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;*
- *assessment and support for treatment regimen adherence and medication management;*
- *identification of available community and health resources;*
- *facilitating access to care and services needed by the patient and/or family;*
- *management of care transitions not reported as part of transitional care management (99495, 99496);*
- *ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;*
- *development, communication, and maintenance of a comprehensive care plan.*

The care management office/practice must have the following capabilities:

- *provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week;*
- *provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;*
- *provide timely access and management for follow-up after an emergency department visit or facility discharge;*
- *utilize an electronic health record system so that care providers have timely access to clinical information;*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

- *use a standardized methodology to identify patients who require care management services;*
- *have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;*
- *use a form and format in the medical record that is standardized within the practice;*
- be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient~~.~~;
- reporting physician or other qualified health care professional oversees activities of the care team;
- all care team members providing services are clinically integrated.

~~E/M services may be reported separately by the same physician or other qualified health care professional during the same calendar month.~~ Each minute of service time is counted toward only one service. Do not count any time and activities used to meet criteria for another reported service. However, time of clinical staff and time of a physician or other qualified health care professional are distinct when each provides a distinct, separately reportable service to the same patient during the same period of time (eg, calendar month). ~~A physician or other qualified health care professional who reports codes 99487, 99489, 99490 may not report care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366, 99367, 99368), education and training (98960, 98961, 98962, 99071, 99078), telephone services (*99366, 99367, 99368, 99441*, 99442, 99443), *on-line medical evaluation (98969, 99444),* preparation of special reports (99080), analysis of data (99091), transitional care management services (99495, 99496), medication therapy management services (99605, 99606, 99607) and, if performed, these services may not be reported separately during the month for which 99487, 99489, 99490 are reported.~~ A list of services not reported in the same calendar month as 99487, 99489, 99490, 99439 is provided in the parenthetical instructions following 99489, 99439. See the parenthetical instruction below 99491 for a list of services not separately reported in the same calendar month that 99491 is reported. ~~All other services may be reported.~~ Do not report 99487, 99489, 99490, 99439 when reporting 99491 for the same calendar month. ~~Do not report 99487, 99489, 99490, 99491 if reporting ESRD services (90951-90970) during the same month.~~ If the care management services are performed within the postoperative period of a reported surgery, the same individual may not report 99487, 99489, 99490, 99491, 99439 ~~when reporting~~. For service time used for ~~*reporting 99487, 99489, 99490,*~~ 99491, 99439, *do not* also include service time used to *report 99421, 99422, 99423.*

Care management may be reported in any calendar month during which the clinical staff time or physician or other qualified health care professional personal time requirements are met. If care management resumes after a discharge during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate. If discharge occurs in the same month, continue the reporting period or report Transitional Care Management Services. Do not report 99487, 99489, 99490, 99491, 99439 for any post-discharge care management services for any days within 30 days of discharge, if reporting 99495, 99496.

When behavioral or psychiatric collaborative care management services are also provided, 99484, 99492, 99493, 99494 may be reported in addition.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Chronic Care Management Services

Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities. Code 99439 is reported in conjunction with 99490 for each additional 20 minutes of clinical staff time spent in care management activities during the calendar month up to a maximum of 60 minutes total time (ie, 99439 may only be reported twice per calendar month). Code 99491 is reported when 30 minutes of physician or other qualified health care professional personal time is spent in care management activities. Do not report 99490, 99439 in the same calendar month as 99491. If reporting 99491, do not count any physician or other qualified health care professional time on the date of a face-to-face E/M encounter towards the time used in reporting 99491.

▲99490	V1	Chronic care management services, ~~at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month,~~ with the following required elements: ▪ multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient~~;~~, ▪ chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline~~;~~, ▪ comprehensive care plan established, implemented, revised, or monitored~~.~~; ▪ first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. ~~(Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)~~ ~~(Do not report 99490 in the same calendar month as 99487, 99489, 99491)~~	XXX	0.61 (Affirmed and Referred to CPT May 2020)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

<table>
<tr>
<td>✚●99439</td>
<td>V2</td>
<td>each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

(Use 99439 in conjunction with 99490)

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

(Chronic care management services of 60 minutes or more and requiring moderate or high complexity medical decision making may be reported using 99487, 99489)

(Do not report 99439 more than twice per calendar month)

(Do not report 99490, 99439 in the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99491, 99605, 99606, 99607)

(Do not report 99490, 99439 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 9X0X1, 9X0X2, 9X0X3, 99441, 99442, 99443)

(Do not report 99490, 99439 when performed during the service time of 99495, 99496, if reporting 99495, 99496)
<table>
<tr><th><u>Total Duration of Staff Care Management Services</u></th><th><u>Chronic Care Management</u></th></tr>
<tr><td><u>Less than 20 minutes</u></td><td><u>Not reported separately</u></td></tr>
<tr><td><u>20 to 39 minutes</u></td><td><u>99490 X 1</u></td></tr>
<tr><td><u>40 - 59 minutes</u></td><td><u>99490 X 1 and 99439 X 1</u></td></tr>
<tr><td><u>60 minutes or more (1 hour or more)</u></td><td><u>99490 X 1 and 99439 X 2 (see also 99487)</u></td></tr>
</table>
</td>
<td>ZZZ</td>
<td>0.54

(Interim for CPT 2021 and Referred to CPT May 2020)</td>
</tr>
</table>

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

G2058		*Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).* *(Do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month).* *(Use G2058 in conjunction with 99490).* *(Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491).*	ZZZ	Request that CMS Delete (2020 work RVU = 0.54)
(f) 99491	V3	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: ▪ multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; ▪ chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; ▪ comprehensive care plan established, implemented, revised, or monitored. (Do not report 99491 in the same calendar month ~~as~~ with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99490, 99439, 99605, 99606, 99607) ~~(Do not report 99491 in conjunction with 99339, 99340)~~ (Do not report 99491 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 9X0X1, 9X0X2, 9X0X3, 99441, 99442, 99443)	XXX	1.45 (Affirmed and Referred to CPT May 2020)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		(Do not report 99491 when performed during the service time of 99495, 99496, if reporting 99495, 99496)		

Complex Chronic Care Management Services

Complex chronic care management services are provided during a calendar month that includes criteria for chronic care management services ~~as well as establishment or substantial revision of a comprehensive care plan~~ including establishing, revising, implementing, or monitoring the care plan; medical, functional, and/or psychosocial problems requiring medical decision making of moderate or high complexity; and clinical staff care management services for at least 60 minutes, under the direction of a physician or other qualified health care professional. ~~Physicians or other qualified health care professionals may not report complex chronic care management services if the care plan is unchanged or requires minimal change (eg, only a medication is changed or an adjustment in a treatment modality is ordered).~~ Medical decision making as defined in the Evaluation and Management (E/M) guidelines is determined by the problems addressed by the reporting individual during the month.

Patients who require complex chronic care management services may be identified…

Total Duration of Staff Care Management Services	***Complex Chronic Care Management***
Less than 60 minutes	*Not reported separately*
60 to 89 minutes (1 hour - 1 hr. 29 min.)	*99487 X 1*
90 - 119 minutes (1 hr. 30 min. - 1 hr. 59 min.)	*99487 X 1 and 99489 X 1*
120 minutes or more (2 hours or more)	*99487 X 1 and 99489 X 2 and 99489 for each additional 30 minutes*

▲99487	V4	Complex chronic care management services, with the following required elements: ▪ multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, ▪ chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,	XXX	1.00 (Affirmed and Referred to CPT May 2020)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		▪ ~~establishment or substantial revision of a comprehensive care plan,~~ ▪ comprehensive care plan established, implemented, revised, or monitored, ▪ moderate or high complexity medical decision making; ▪ 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. *(Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)*		
✚▲99489	V5	each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) *(Report 99489 in conjunction with 99487)* *(Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month)* (Do not report 99487, 99489~~, 99490~~ during the same calendar month with 90951-90970, ~~93792~~, ~~93793~~, ~~98960-98962~~, ~~98966, *98967, 98968*~~ ~~99071, 99078, 99080, 99091~~, 99339, 99340, ~~99358, 99359, 99366-99368~~, 99374, 99735, 99377, 99378, 99379, ~~-~~99380, ~~99441, 99442, 99443~~, 94490, 99491, 99439, 99605~~-~~, 99606, 9960799~~495, 99496~~) (Do not report 99487, 99489 for service time reported with 93792, 93793, 98960, 98961,-98962, 98966, 98967, 98968, 98969, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, *9X0X1, 9X0X2, 9X0X3,* 99441, 99442, 99443) (Do not report 99487, 99489 when performed during the service time of 99495, 99496, if reporting 99495, 99496)	ZZZ	0.50 (Affirmed and Referred to CPT May 2020)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

General Behavioral Health Integration Care Management

General behavioral health integration care management services (99484) are reported by the supervising physician or other qualified health care professional. The services are performed by clinical staff for a patient with a behavioral health (including substance use) condition that requires care management services (face-to-face or non-face-to-face) of 20 or more minutes in a calendar month. A treatment plan as well as the specified elements of the service description is required. The assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management (99487, 99489, 99490, 99439). Code 99484 may be used in any outpatient setting, as long as the reporting professional has an ongoing relationship with the patient and clinical staff and as long as the clinical staff is available for face-to-face services with the patient.

The reporting professional must be able to perform the evaluation and management…

#99484 *Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:*

- *initial assessment or follow-up monitoring, including the use of applicable validated rating scales;*
- *behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;*
- *facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, and/or psychiatric consultation; and*
- *continuity of care with a designed member of the care team.*

(Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month)

(E/M services, including care management services [99487, 99489, 99490, 99439, 99495, 99496], and psychiatric services [90785-90899] may be reported separately by the same physician or other qualified health care professional on the same day or during the same calendar month, but time and activities used to meet criteria for another reported service do not count toward meeting criteria for 99484)

Medicine
Cardiovascular
Home and Outpatient International Normalized Ratio (INR) Monitoring Services

Home and outpatient international normalized ratio…

If significantly, separately identifiable evaluation and management (E/M)…

Do not report 93793 on the same day…

Do not report 93792, 93793 in conjunction with 98966, 98967, 98968, 98X00, 98X01, 98X02, *9X0X1, 9X0X2, 9X0X3,* 99441, 99442, 99443 when telephone or online *digital evaluation and management* services address home and outpatient INR monitoring.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Do not report 93792, 93793 when performed during the service ~~time~~ period of ~~99487, 99489, 99490,~~ 99495, 99496. Do not count time spent in 93792, 93793 in the time of 99487, 99489, 99490, 99439, 99491 when reported in the same calendar month.

93792 Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results

(For provision of test materials and equipment for home INR monitoring, see 99070 or the appropriate supply code)

93793 Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed

(Do not report 93793 in conjunction with ~~99201,~~ 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245)

(Report 93793 no more than once per day, regardless of the number of tests reviewed)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE
Research Subcommittee Conference Call Report

Tuesday, November 5th

Members Present: Ezequiel Silva III, MD (Chair), Jimmy Clark, MD (Vice Chair), Dale Blasier, MD, Gregory DeMeo, MD, Peter Hollmann, MD, Omar Hussain, MD, Katie Jordan, OTD, OTR/L, M. Douglas Leahy, MD, Daniel McQuillen, MD, Guy Orangio, MD, Marc Raphaelson, MD, David Slotwiner, MD, Michael Sutherland, MD, Timothy Tillo, DPM, Robert Zwolak, MD

I. Chronic Care Management Services (CCM) (99490, 99439, 99491, 99487, 99489)

American Academy of Family Physicians
American College of Physicians
American Geriatrics Society
American Nurses Association
American Osteopathic Association

The original agenda for this conference call was to review proposed custom RUC survey templates on physician work and clinical labor and also two proposed reference service lists. However, at the beginning of the call, the presenting specialties explained that coding and policy changes related to care management services finalized by CMS in the CY2020 Medicare Physician Payment Schedule Final Rule, released on November 1, would necessitate the delay of surveying CCM codes 99490, 99439, 99491, 99487 and 99489 until the CPT 2022 cycle.

The specialties noted that two new G codes created by CMS for Principal Care Management (PCM) services (G2064 and G2065) should be reviewed concurrently with the CCM codes as they are part of the same family. The specialties stated their intent to submit a CCA for the PCM/CCM codes to address material changes across the family in the CY2020 MPFS Final Rule, as further discussed below.

The specialty societies explained the relevant changes from the CY2020 MPFS Final Rule in detail:

- *Principal Management Services:* The Agency created two new G codes, (G2064 and G2065) to make separate payment for care management for patients with one serious chronic condition. Principal care management services are similar to CCM services, however CCM services are furnished for care management of patients with two or more chronic conditions. A serious chronic condition would be a condition lasting 3 months to 1 year, may have led to a hospitalization, placed the patient at significant risk of death, the condition may have been exacerbated or caused significant functional decline. G2064 is reported when at least 30 minutes in 30 calendar days is spent by the physician or other qualified health care provider and G2065 is reported when at least 30 minutes of clinical staff time is spent within 30 calendar days.
- CMS will interpret the code descriptor "establishment or substantial revision of a comprehensive care plan" in 99487 and 99489 to mean that a comprehensive care plan is established, implemented, revised, or monitored identical to the descriptor of 99490. CMS stated that it would allow for consistency in the care planning service element of complex CCM and non-complex CCM services provided by clinical staff.
- CMS also created an add-on code for 99490 for additional 20-minute increments of non-complex CCM clinical staff time. This add-on code, HCPCS code G2058, will be reportable a maximum of two times within a given service period for a given beneficiary.

AMA RUC staff noted that the CCM section was revised extensively by the CPT Editorial Panel for CPT 2021, including the creation of new add-on code 99439 and the revision of several existing codes, and that the January 2020 RUC meeting is the last RUC meeting of the CPT 2021 cycle. The Subcommittee

inquired whether the specialties workplan was to propose to delay the CPT coding changes until CPT 2022 or if they had a plan for how to handle the new and revised codes in the CCM section of CPT. The specialties suggested that the values for the revised codes for CY2020 (99490, 99491, 99487, 99489) could also be maintained for CY2021 and the value of the new code (99439) could come from a RUC-approved crosswalk. Once this code family has gone through the CPT Editorial Panel process, then all the impacted care management codes could be surveyed for the CPT 2022 cycle. The Subcommittee members agreed that this workplan for the multispecialty advisory committee's recommendation to the RUC seems reasonable given the time constraints for the CPT 2021 cycle and changes that were just finalized in the CY2020 Final Rule.

The Research Subcommittee recommends that the RUC approve the specialty approved work plan for these codes:

- **Maintaining the work values and direct practice expense inputs for codes 99490, 99491, 99487 and 99489 for CPT 2021 on an interim basis**
- **Propose an appropriate interim crosswalk for 99439 for CPT 2021**
- **After the anticipated CPT EP action on the existing CCM codes, the entire family including the new Principal Management Services codes, will be surveyed in calendar year 2020 for the CPT 2022 cycle (for the RUC meeting immediately following the CPT panel action).**
- **By the December 17, 2019 submission deadline, the specialty will:**
    - **Submit an Summary of Recommendation (SOR) for code 99439 with a proposed crosswalk for CPT 2021**
    - **Submit a PE spreadsheet with all existing inputs and a PE SOR for code 99439**
    - **Submit a RUC summary spreadsheet for codes 99490, 99491, 99487, 99489 and 99439**
    - **Provide a letter explaining the background for this code family and their recommendations for CPT 2021 and their intentions for CPT 2022 (including the information in the first three bullets described above).**

The Chair of the RUC noted that this recommendation by the Subcommittee would be circulated to the full RUC electronically for the RUC's consideration shortly after the call.

Dear Dr. Smith

The undersigned specialty societies are writing to provide additional background as to why we are recommending an interim crosswalk for new CPT code 99439 instead of doing a survey for the January 2020 RUC meeting.

At its September 2019 meeting, the CPT Editorial Panel established a new add-on code 99439, Chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month to be used with 99490, Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

This new code is part of the chronic care management (CCM) family, and several societies, including the American College of Physicians, the American Academy of Family Physicians, the American Geriatrics Society, the American Osteopathic Association, and the American Nurses Association, submitted LOI's of 1 to survey the family. During the process of the societies preparing for the survey, CMS published its final rule for CY 2020, which included the creation of several new care management HCPCS codes. These included two codes for principal care management and code G2058, which has a descriptor identical to that of 99439.

When these codes came out, the specialty society advisors met by conference call and decided to submit a code change proposal to CPT for the May 2020 meeting. This proposal would establish new principal care management codes (like those in the final rule). Because these new codes also would potentially be part of the CCM family, the entire CCM family would need to be surveyed after the codes were approved by CPT. Specifically, assuming the new principal care management codes are approved at the May 2020 CPT meeting, the entire CCM family will need to be surveyed for the October 2020 RUC meeting. Therefore, if the undersigned specialties surveyed the CCM family for the January 2020 RUC meeting because of new code 99439, that would mean the exact same family of codes would be surveyed for both the January and October RUC meetings in 2020. For many reasons, the undersigned specialty society do not think that is a good idea (e.g., the work is unlikely to change in such a short period of time, any differences in the results may cast on the validity of both surveys, respondents completing both surveys may be confused by the request to resurvey the same codes).

Given that CMS had already established payment for the new codes for CY 2020 (including G2058), the undersigned specialties met with the Research Subcommittee and requested that we be allowed to make a presentation to the RUC requesting a temporary crosswalk to value 99439 on an interim basis for 2021 before it is surveyed next year as part of the 2022 CPT and Medicare physician fee schedule cycles. The specialties also requested that we be allowed to recommend maintaining the current value of the existing CCM codes until the entire family is surveyed later in 2020. The Research subcommittee listened to our proposal, asked several helpful questions, and expressed its support for the proposed plan. The SoR we submitted for

99439 contains a more detailed discussion of the process and our recommendations for a crosswalk.

Thanks to you and the RUC for your time and consideration of this matter. We look forward to discussing it with the RUC in January.

Sincerely,

American Academy of Family Physicians
American College of Physicians
American Geriatrics Society
American Nurses Association
American Osteopathic Association

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99439 Tracking Number V2 Original Specialty Recommended RVU: **0.54**
Presented Recommended RVU: **0.54**
Global Period: ZZZ Current Work RVU: **N/A** RUC Recommended RVU: **0.54**

CPT Descriptor: Chronic care management services, with the following required elements:

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

each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
(Use 99439 in conjunction with 99490)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: (not applicable)

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: (not applicable)

Description of Intra-Service Work: Chronic care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility. These services typically involve clinical staff implementing a care plan directed by the physician or other qualified health care professional when medical and/or psychosocial needs of the patient require establishing and implementing, revising, or monitoring the care plan. Services typically include establishing, implementing, revising, or monitoring the care plan; coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.

A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community and social services ordered, how the services of agencies and specialists unconnected to the practice will be directed and coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.

The care management office/practice must have the following capabilities:
Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients and caregivers with a means to make contact with health care professionals in the practice to address urgent needs

regardless of the time of day or day of week; provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; provide timely access and management for follow up after an emergency department visit or facility discharge; utilize an electronic health record system so that care providers have timely access to clinical information; use a standardized methodology to identify patients who require care management services; have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner; use a form and format in the medical record that is standardized within the practice; be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Description of Post-Service Work: (not applicable)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2020
Presenter(s):	Megan Adamson, MD; Amy Aronsky, DO; Audrey Chun, MD; Joshua Liao, MD, MS, FACP; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Elisabeth Volpert, DNP, APRN, FNP-C
Specialty Society(ies):	American Academy of Family Physicians, American College of Physicians, American Geriatrics Society, American Nurses Association, American Osteopathic Association
CPT Code:	99439
Sample Size: 0	**Resp N:** 0
Description of Sample:	not applicable

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:					
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:			**0.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code: 99439	**Recommended Physician Work RVU: 0.54**		
	Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:	**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:	**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:	**0.00**	**0.00**	**0.00**
Intra-Service Time:	**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
11107	ZZZ	0.54	**RUC Time**

CPT Descriptor Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96171	ZZZ	0.54	**RUC Time**

CPT Descriptor Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77001	ZZZ	0.38	**RUC Time**	402,771

CPT Descriptor 1 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
77002	ZZZ	0.54	**RUC Time**	474,947

CPT Descriptor 2 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 **% of respondents:** 0.0 **%**

Number of respondents who choose 2nd Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 99439	**Top Key Reference CPT Code:** 11107	**2nd Key Reference CPT Code:** **96171**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**15.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			

Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT established a new add-on code 99439, Chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month to be used with 99490,

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

This new code is part of the chronic care management (CCM) family and several societies, including the American College of Physicians, the American Academy of Family Physicians, the American Geriatrics Society, the American Osteopathic Association, and the American Nurses Association, submitted LOI's of 1 to survey the family. During the process of preparing for the survey, CMS published it final rule for CY 2020, which included the creation of several new CCM codes. These included two codes for principal care management and a G2058 which has a descriptor identical to that of 99439. When these came out, the specialty society advisors decided to submit a coding change proposal to CPT to establish new principal care management codes. Those codes also would be part of the CCM family and would necessitate surveying the entire CCM family. Because the soonest the new codes could be created was for the CY 2022 CPT cycle, that meant the entire CCM family would have to be reviewed 2 years in row if the proposed survey for 99439 was done.

Given that CMS had already established payment for the new codes for CY 2020 (including G2058), the specialties met with the Research Subcommittee and requested that they be allowed to make a presentation to the RUC requesting a temporary crosswalk to value 99439 on an interim basis before it was surveyed next year. The Research subcommittee agreed with this plan. Therefore, specialty societies convened an expert panel of their RUC advisors, which met by conference call to discuss an appropriate crosswalk. They noted that CMS assigned 0.54 work RVUs and 15 minutes of total (all intra-service) time to G2058. The expert panel also reviewed the RVUs of other RUC-reviewed, ZZZ global codes with total time of 10-20 minutes and work RVUs between 0.30 and 0.70. Within that group of codes, there were 15 codes that had 15 minutes of total time (all intra-service), including two codes for acupuncture reviewed by the HCPAC. Several of those codes support the recommended value of 0.54:

11045, Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) with 0.50 work RVUs

11107, Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure) with 0.54 work RVUs

90913, Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure) with 0.50 work RVUs

96159, Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service) with 0.50 work RVUs

96168, Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) with 0.55 work RVUs

96171, Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) with 0.54 work RVUs

96571, Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract) with 0.55 work RVUs

97811, Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) with 0.50 work RVUs

97814, Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure) with 0.55 work RVUs

The expert panel also noted that 99489, Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care

professional, per calendar month (List separately in addition to code for primary procedure) has 13 total minutes, all intra-service, and a work RVU of 0.5. The panel also noted that the base complex CCM code, 99487, Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month has a total time of 45 minutes and a work RVU of 1.00.

In order to maintain the work relativity of 99487, 99489, 99490, and 99439, given the time for each code, the expert panel believes that the most appropriate crosswalks are 11107 and 96171, because the amount of work required for the add-on code should be less than the base code and within the range of other ZZZ global codes with 15 minutes of total time, all intra-service.

Therefore, the specialty societies are recommending 0.54 work RVUs and 15 minutes to total time, all intra-service for CPT code 99439 as interim values until the entire CCM family is surveyed next year.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre Time	Intra Time	Post Time
3.	99490	XXX	0.61	0	15	0
4.	99439	ZZZ	0.54	0	15	0
5.	Totals>		1.15	0	30	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99490

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Family medicine How often? Commonly

Specialty Internal medicine How often? Commonly

Specialty Geriatrics How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1216342

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Same as estimated Medicare frequency; most private payers are not paying for CCM, and most non-Medicare patients don't qualify.

Specialty Family medicine Frequency 383148 Percentage 31.50 %

Specialty Internal medicine Frequency 490672 Percentage 40.33 %

Specialty Geriatrics Frequency 12163 Percentage 0.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,216,342 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CMS estimate of utilization for G2058; 30% of 2018 utilization of 99490

Specialty Family medicine Frequency 383148 Percentage 31.50 %

Specialty Internal medicine Frequency 490672 Percentage 40.33 %

Specialty Geriatrics Frequency 12163 Percentage 0.99 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99490

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

1st REF = Top Key Reference code data

2st REF = Second Highest Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Chronic Care Management Services

TAB: 20

							RVW						PRE-TIME			INTRA-TIME					IMMD
Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
CURRENT	99487	XXX	Complex chronic care management se		0.038			1.00			26						26			
REC	99487	XXX	Complex chronic care management se		0.038			1.00			26						26			

							RVW						PRE-TIME			INTRA-TIME					IMMD
Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
CURREN	99489	ZZZ	Complex chronic care management se		0.038			0.50			13						13			
REC	99489	ZZZ	Complex chronic care management se		0.038			0.50			13						13			

							RVW						PRE-TIME			INTRA-TIME					IMMD
Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
CURRENT	99490	XXX	Chronic care management services, at		0.041			0.61			15						15			
REC	99490	XXX	Chronic care management services, at		0.041			0.61			15						15			

							RVW						PRE-TIME			INTRA-TIME					IMMD
Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
1st REF	11107	ZZZ	Incisional biopsy of skin (eg, wedge) (		0.036			0.54			15						15			
2nd REF	99490	XXX	Chronic care management services, at		0.041			0.61			15						15			
CURRENT	994XX	ZZZ	Chronic care management services, w		#DIV/0!						0									
REC	99439	ZZZ	Chronic care management services, w		0.036			0.54			15						15			

							RVW						PRE-TIME			INTRA-TIME					IMMD
Source	CPT	Global	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
CURRENT	99491	XXX	Chronic care management services, pr		0.048			1.45			30						30			
REC	99491	XXX	Chronic care management services, pr		0.048			1.45			30						30			

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 99490, 99439, 99491, 99487, 99489**
SPECIALTY SOCIETY(IES): AAFP, ACP, AGS, ANA, AOA
PRESENTER(S): Megan Adamson, MD; Amy Aronsky, DO; Audrey Chun, MD; Joshua Liao, MD, MS, FACP; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA; Elisabeth Volpert, DNP, APRN, FNP-C

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2020

CPT Code	Long Descriptor	Global Period
99490	Chronic care management services, with the following required elements: ▪ multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient~~,~~; ▪ chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline~~,~~; ▪ comprehensive care plan established, implemented, revised, or monitored~~.~~; ▪ first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	XXX
99439	each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	ZZZ
99491(f)	*Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:* ▪ *multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;* ▪ *chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;* ▪ *comprehensive care plan established, implemented, revised, or monitored.*	XXX
99487	Complex chronic care management services, with the following required elements: ▪ multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, ▪ chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, ▪ comprehensive care plan established, implemented, revised, or monitored, ▪ moderate or high complexity medical decision making;	XXX

	▪ 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.	
99489	each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99490	The patient is a 75-year-old female with diabetes, hypertension, and mild congestive heart failure. She requires chronic care management services.
99439	During a month of chronic care management services, a 78-year-old female who has just received 39 minutes of clinical staff time, requires additional care management services. **Note**: This is an add-on service. Only consider the additional work related to additional clinical staff time.
99491(f)	**Typical Patient (RUC Database) (99491) Child** A 6-year-old child with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airway disease, chronic seizure disorder, failure to thrive, and severe neurodevelopment delay. He receives home occupational, physical, and speech therapy services. **Typical Patient (RUC Database) (99491) Adult** An 83-year-old female with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program, and sees a cardiologist and neurologist.
99487	**Typical Patient (99487) Child** A 6-year-old child with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airway disease, chronic seizure disorder, failure to thrive and severe neurodevelopment delay. He receives home occupational, physical and speech therapy services. **Typical Patient (99487) Adult** An 83-year-old female with congestive heart failure, early cognitive dysfunction, and takes four medications. She has decompensated and requires ongoing management aimed at avoiding further decompensation.
99489	**Typical Patient (99489) Adult** During a month of complex chronic care management services, a 92-year-old male with congestive heart failure, diabetes, and dementia and who has already received 89 minutes of complex care management services requires additional clinical staff time and ongoing care management

	activities. **Note**: This is an add-on service. Only consider the additional work related to complex chronic care management beyond the first 89 minutes.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   RUC advisors from all the participating specialty societies acted as an expert panel and met by email and conference call to arrive at the recommendations for direct practice expense inputs. Prior final submissions for each service serviced as the basis with no modifications other than to make consistent with the current PE forms and the new code language.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   Current CMS time per the 2020 final rule. In some codes we moved the minutes from CA002 and CA035 to **CA021** as we believe placing time in those line items are likely typo mistakes and we do not believe the time should be in pre or post service for this code family.
   For 99439 as there is no current, we selected the code time.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   From RUC data base 2019 version 2 in varying top percentages based on the CPT code.
   Internal Medicine, Family Medicine, Nurse Practitioner, Physician Assistant, Cardiology, Pediatrics

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling*

evidence guidelines) Please explain if the increase can be entirely accounted for because of an increase in physician time:

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:
   b. Service period (includes pre, intra and post):

From CPT directly:
Care management activities performed by clinical staff, or personally by the physician or other qualified health care professional, typically include:

- communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family;
- management of care transitions not reported as part of transitional care management (99495, 99496);
- ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;
- development, communication, and maintenance of a comprehensive care plan.

When above are personally performed by physician or QHP, CPT 99491, the below are the clinical staff activities in addition to the 30 minutes by the physician or QHP:
The clinical staff perform the following tasks over the month the service is furnished:

- Call(s) in or email prescription(s)
- communicate with the patient or caregiver if the physician is not available

- receive, review and send tests results and other clinical information to and from other care givers
- schedule appointment(s) with other healthcare providers and outside agencies
- take call(s) from patient or contact patient when MD available for call

c. Post-service period:

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

For 99491 only
Detail breakout of Intra-service Clinical Staff:
Five minutes per month in relaying/communicating patient messages,
five minutes in communication with patient and/or pharmacy for prescription refills, prior authorizations or clarifications (assisting physician with paperwork for DME may be included here, or separately)
and five minutes for coordination with outside agencies or other providers (i.e. Obtaining referral forms, tracking down documentation of care received outside the primary care office or tracking down results on tests ordered by provider other that the PCP for a total time of 15 minutes.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

19. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

20. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

21. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

22. If this is a PE only code please select a crosswalk based on a similar specialty mix:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

ITEMIZED LIST OF CHANGES FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT CY 2020 FR**		**Recommendation**		**CURRENT CY 2020 FR**		**CURRENT CY 2020 FR**		**CURRENT**
2						**99490**		**99490**		**99439 Add-On**		**99491**		**99487**		**99489 Add**
3		***RUC Collaboration Website***				CCM... - **at least 20 minutes of clinical staff time** directed by a physician or other		CCM... - **first 20 minutes of clinical staff time** directed by a physician or other qualified health care		CCM…-**each additional 20 minutes of clinical staff time** directed by a physician or other		CCM….-provided personally **by a physician** or other qualified health care professional**, at least**		CCCM… 60 minutes of clinical staff time directed by physician or other qualified health care		CCCM additional of clinical directe physician
4	**Clinical Activity Code**	**Meeting Date: January 2020 Revision Date (if applicable): Tab: 20 Specialty: AAFP, ACP, ANA, AOA, AGS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**											
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**		**XXX**		**ZZZ**		**XXX**		**XXX**		**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 7.40**	**$ -**	**$ 7.40**	**$ -**	**$ 7.40**	**$ -**	**$ 5.55**	**$ -**	**$ 30.60**	**$ -**	**$ 15.30**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**20.0**	**0.0**	**20.0**	**0.0**	**20.0**	**0.0**	**0.0**	**0.0**	**60.0**	**0.0**	**30.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**20.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**			
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**20.0**	**0.0**	**20.0**	**0.0**	**15.0**	**0.0**			
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**			
12		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L051A	RN	0.51									**0.0**	**0.0**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L051A	RN	0.51									**60.0**	**0.0**	**30.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L051A	RN	0.51									**0.0**	**0.0**	**0.0**
15		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 7.40**	**$ -**	**$ 7.40**	**$ -**	**$ 7.40**	**$ -**	**$ 5.55**	**$ -**	**$ 30.60**	**$ -**	**$ 15.30**
16		**PRE-SERVICE PERIOD**														
17		**Start: Following visit when decision for surgery/procedure made**														
18	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37											
19	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37	20										
29		~~Other activity: please include short clinical description here and type new in column A~~	L037D	RN/LPN/MTA	0.37											
32		**End: When patient enters office/facility for surgery/procedure**														
33		**SERVICE PERIOD**														
34		**Start: When patient enters office/facility for surgery/procedure:**														
35		**Pre-Service (of service period)**														
48		~~Other activity: please include short clinical description here and type new in column A~~	L037D	RN/LPN/MTA	0.37											
51		**Intra-service (of service period)**														
55	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37			20		20		15				
58	CA021	Perform procedure/service---NOT directly related to physician work time	L051A	RN	0.51									60		30
59			L037D	RN/LPN/MTA	0.37											
63		**Post-Service (of service period)**														
77	CA035	Review home care instructions, coordinate visits/prescriptions	L051A	RN	0.51											
84		~~Other activity: please include short clinical description here and type new in column A~~	L037D	RN/LPN/MTA	0.37											
85		**End: Patient leaves office/facility**														
86		**POST-SERVICE PERIOD**														
87		**Start: Patient leaves office/facility**														
88	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37											
89	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37											
100		~~Other activity: please include short clinical description here and type new in column A~~	L037D	RN/LPN/MTA	0.37											
101		~~Other activity: please include short clinical description here and type new in column A~~	L037D	RN/LPN/MTA	0.37											
102		~~Other activity: please include short clinical description here and type new in column A~~	L037D	RN/LPN/MTA	0.37											
103		**End: with last office visit before end of global period**														

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT CY 2020 FR**		**Recommendation**		**CURRENT CY 2020 FR**		**CURRENT CY 2020 FR**		**CURRENT**
2						**99490**		**99490**		**99439 Add-On**		**99491**		**99487**		**99489 Add**
3		***RUC Collaboration Website***				CCM... - **at least 20 minutes of clinical staff time** directed by a physician or other		CCM... - **first 20 minutes of clinical staff time** directed by a physician or other qualified health care		CCM…-**each additional 20 minutes of clinical staff time** directed by a physician or other		CCM….-provided personally **by a physician** or other qualified health care professional**, at least**		CCCM… 60 minutes of clinical staff time directed by physician or other qualified health care		CCCM additional of clinical directe physician
4	**Clinical Activity Code**	**Meeting Date: January 2020 Revision Date (if applicable): Tab: 20 Specialty: AAFP, ACP, ANA, AOA, AGS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**											
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**		**XXX**		**ZZZ**		**XXX**		**XXX**		**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 7.40**	**$ -**	**$ 7.40**	**$ -**	**$ 7.40**	**$ -**	**$ 5.55**	**$ -**	**$ 30.60**	**$ -**	**$ 15.30**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**20.0**	**0.0**	**20.0**	**0.0**	**20.0**	**0.0**	**0.0**	**0.0**	**60.0**	**0.0**	**30.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**20.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**			
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**20.0**	**0.0**	**20.0**	**0.0**	**15.0**	**0.0**			
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**			
12		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L051A	RN	0.51									**0.0**	**0.0**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L051A	RN	0.51									**60.0**	**0.0**	**30.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L051A	RN	0.51									**0.0**	**0.0**	**0.0**
104	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**												
105		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
106																
107																
112		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*														
113																
114	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**											
115		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
116																
121																
122		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*														

	A	B	R
1	**RUC Practice Expense Spreadsheet**		**CY 2020 FR**
2			**l-On Code**
3		***RUC Collaboration Website***	...each
4	**Clinical Activity Code**	**Meeting Date: January 2020** **Revision Date (if applicable):** **Tab: 20** **Specialty: AAFP, ACP, ANA, AOA, AGS**	30 minutes staff time d by a or other
5		**LOCATION**	**Facility**
6		**GLOBAL PERIOD**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	
12		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**
15		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**
16		**PRE-SERVICE PERIOD**	
17		**Start: Following visit when decision for surgery/procedure made**	
18	CA001	Complete pre-service diagnostic and referral forms	
19	CA002	Coordinate pre-surgery services (including test results)	
29		*Other activity: please include short clinical description here and type new in column A*	
32		**End: When patient enters office/facility for surgery/procedure**	
33		**SERVICE PERIOD**	
34		**Start: When patient enters office/facility for surgery/procedure:**	
35		**Pre-Service (of service period)**	
48		*Other activity: please include short clinical description here and type new in column A*	
51		**Intra-service (of service period)**	
55	CA021	Perform procedure/service---NOT directly related to physician work time	
58	CA021	Perform procedure/service---NOT directly related to physician work time	
59			
63		**Post-Service (of service period)**	
77	CA035	Review home care instructions, coordinate visits/prescriptions	
84		*Other activity: please include short clinical description here and type new in column A*	
85		**End: Patient leaves office/facility**	
86		**POST-SERVICE PERIOD**	
87		**Start: Patient leaves office/facility**	
88	CA037	Conduct patient communications	
89	CA038	Coordinate post-procedure services	
100		*Other activity: please include short clinical description here and type new in column A*	
101		*Other activity: please include short clinical description here and type new in column A*	
102		*Other activity: please include short clinical description here and type new in column A*	
103		**End: with last office visit before end of global period**	

	A	B	R
1	**RUC Practice Expense Spreadsheet**		**CY 2020 FR**
2			**d-On Code**
3		***RUC Collaboration Website***	...each
4	**Clinical Activity Code**	**Meeting Date: January 2020** **Revision Date (if applicable):** **Tab: 20** **Specialty: AAFP, ACP, ANA, AOA, AGS**	30 minutes staff time ed by a or other
5		**LOCATION**	**Facility**
6		**GLOBAL PERIOD**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	
12		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**
104	**Supply Code**	**MEDICAL SUPPLIES**	
105		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**
106			
107			
112		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*	
113			
114	**Equipment Code**	**EQUIPMENT**	
115		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**
116			
121			
122		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2014

Chronic Care Management

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

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

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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

performed by clinical staff and (2c) asked about clinical staff activities performed by the physician. *Please see the attached document and spreadsheet providing this additional information on clinical staff time further breakdown.*

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

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

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

The RUC reviewed the survey results from 338 physicians for CPT code 99490 and determined that the survey 25th percentile work RVU of 1.00 and 30 minutes intra-service time appropriately accounted for the work required to perform this service. The specialty societies indicated and the RUC agreed that the physician work of supervising chronic care management required for 99490 is the same as 99487 *Complex chronic care management* (RUC recommended work RVU = 1.00), which also includes 60 minutes of clinical staff time. The RUC noted that the survey median work RVU of 1.50 would cause a rank order anomaly. The RUC also compared 99490 to the key reference service 99214 and determined that the work and physician time required to perform 99490 is less, therefore is appropriately valued lower. The RUC confirmed the proper rank order with the following Evaluation and Management services: 99367 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician* (work RVU = 1.10), 99339 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities…15-29 minutes* (work RVU = 1.25), 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and 99340 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities…30 minutes or more* (work RVU = 1.80). For additional support the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report* (work RVU = 0.85). **The RUC recommends a work RVU of 1.00 for CPT code 99490.**

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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

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

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
~~Complex Chronic~~ Care ~~Coordination~~Management Services ~~Complex chronic care coordination~~Care management services are ~~patient centered~~ management and support services provided by ~~physicians~~clinical staff, under the direction of a physician or other qualified health care professionals~~, and clinical staff~~ to a~~n individual who resides~~ patient residing at home or in a domiciliary, rest home, or assisted living facility. ~~These services typically involve clinical staff developing~~Services may include establishing, ~~substantially~~implementing, revising, ~~and implementing a care plan under direction of the physician~~ or ~~other qualified health care professional. Substantial revision to a~~monitoring the care plan ~~typically occurs when~~, coordinating the ~~patient's clinical condition changes sufficiently (eg, identification of a new problem requiring additional interventions, introduction of new interventions because existing interventions are deemed ineffective, exacerbation~~care of ~~an existing problem requiring new interventions) to require more intensive staff monitoring, changes in the treatment regimen~~other professionals and agencies, and ~~additional time to educate~~educating the patient ~~and/~~or caregiver about the patient's condition ~~and/or change in treatment~~, care plan, and prognosis. The~~se services address the coordination of care by multiple professionals, disciplines, and/~~ physician or ~~community service agencies. The reporting individual~~other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, ~~and instrumental~~ and ~~basic~~ activities of daily living ~~(IADL/ADL)~~. ~~Patients who require complex chronic care coordination services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, and/or repeat admissions or emergency department visits. Typical adult patients take or receive three or more prescription medications and may also be receiving other types of therapeutic interventions (eg, physical therapy, occupational therapy) and have two or more chronic continuous or~~				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Typical pediatric patients receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy) and have two or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. In some cases, due to inability to perform IADL/ADL and/ or cognitive impairment the patient is unable to adhere to the treatment plan without substantial assistance from a caregiver. For example, patients may have medical and psychiatric behavioral co-morbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care. Social support requirements or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are required. Medical decision making as defined in the Evaluation and Management (E/M) guidelines is not only applied to the face-to-face services, but is determined by the nature of the problems addressed by the reporting individual during the month.

A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.

Codes 99487-9948999487, 99489, 99490 are reported only **once**once per calendar month and include all non-face-to-face complex chronic care coordination services and none or 1 face-to-face office or other outpatient, home, or domiciliary visit. Physicians or other qualified health care professionals may not report care coordination services if the care plan is unchanged or requires minimal change (eg, only a medication is changed or an adjustment in a treatment modality is ordered). Codes 99487-99489 may only be reported by the single physician or other qualified health care professional who assumes the care coordinationmanagement role with a particular patient for the calendar month.

Code selection is as follows:

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

~~Code 99487 is reported when, during the calendar month, there is no face-to-face visit with the physician or other qualified health care professional and at least 31 minutes of clinical staff time is spent in care coordination activities. 99488 is reported when, during the calendar month, there is a face-to-face visit with the physician or other qualified health care professional and at least 31 minutes of clinical staff time is spent in care coordination activities.~~

The face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals and agencies; revising, documenting and implementing the care plan; or teaching self-management is used in determining the ~~complex chronic~~ care ~~coordination~~management clinical staff time for the month. Only the time of the clinical staff of the reporting professional is counted. Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient. **Note:** Do not count any clinical staff time ~~on the date of the first visit or~~ on a day when the physician or qualified health care professional reports an E/M service (office or other outpatient services ~~99211-99215~~99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services ~~99334-99337~~99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services ~~99347-99350~~99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350).

Care ~~coordination~~management activities performed by clinical staff typically include:

- communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/~~caretaker~~caregiver education to support self-management, independent living, and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family;
- management of care transitions not reported as part of transitional care management (99495, 99496);
- ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;

development, communication, and maintenance of a comprehensive care plan.

The care ~~coordination~~management office/practice must have the following capabilities:

- provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

week;

- provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- provide timely access and management for follow-up after an emergency department visit or facility discharge;
- utilize an electronic health record system so that care providers have timely access to clinical information;
- ~~use~~ use a standardized methodology to identify patients who require ~~chronic complex~~ care ~~coordination~~management services;
- have an internal care ~~coordination~~management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;
- use a form and format in the medical record that is standardized within the practice; be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

~~If a face-to-face visit was provided during the month by the physician or other qualified health care professional, report 99488. Additional~~ E/M services ~~beyond the first visit~~ may be reported separately by the same physician or other qualified health care professional during the same calendar month. ~~Complex care coordination~~Care management services include care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (~~99366-9936899366, 99367, 99368~~), education and training (~~98960-9896298960, 98961, 98962~~, 99071, 99078), telephone services (~~98966-9896899366, 99367, 99368~~, ~~99441-9944399441, 99442, 99443~~), on-line medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), transitional care management services (99495, 99496), medication therapy management services (~~99605-9960799605, 99606, 99607~~) and, if performed, these services may not be reported separately during the month for which ~~99487-9948999487, 99489~~ are reported. All other services may be reported. Do not report ~~99487-9948999487, 99489, 99490~~ if reporting ESRD services (90951-90970) during the same month. If the ~~complex chronic~~ care ~~coordination~~management services are performed within the postoperative period of a reported surgery, the same individual may not report ~~99487-9948999487, 99489, 99490~~.

~~Complex chronic care coordination can~~Care management may be reported in any calendar month during which the clinical staff time requirements are met. If care ~~coordination~~management resumes after a discharge during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate. If discharge occurs in the same month, continue the reporting period or report Transitional Care Management Services. Do not report ~~99487-9948999487, 99489, 99490~~ for any post-discharge ~~complex chronic~~ care ~~coordination~~management services for any days within 30 days of discharge, if reporting 99495, 99496.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

~~Total Duration of Staff Care Coordination Services~~	~~Code(s)~~
~~Less than 30 minutes~~	~~Not reported separately~~
~~31 to 74 minutes (31 minutes - 1 hr. 14 min.)~~	~~99487 or 99488 x 1~~
~~75 - 104 minutes (1 hr. 15 min. - 1 hr. 44 min.)~~	~~99487 or 99488 x 1 and 99489 x 1~~
~~5 minutes or more (1 hr. 45 min. or more~~	~~99487 or 99488 x 1 and 99489 x 2 or more for each additional 30 minutes~~

Chronic Care Management Services

Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities.

●99490	PP1	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: ▪ multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, ▪ chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, ▪ comprehensive care plan established, implemented, revised, or	XXX	1.00

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		monitored. (Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately		

Complex Chronic Care Management Services

Complex chronic care management services are provided during a calendar month that includes criteria for chronic care management services as well as establishment or substantial revision of a comprehensive care plan; medical, functional, and/or psychosocial problems requiring medical decision making of moderate or high complexity; and clinical staff care management services for at least 60 minutes, under the direction of a physician or other qualified health care professional. Physicians or other qualified health care professionals may not report complex chronic care management services if the care plan is unchanged or requires minimal change (eg, only a medication is changed or an adjustment in a treatment modality is ordered). Medical decision making as defined in the Evaluation and Management (E/M) guidelines is determined by the problems addressed by the reporting individual during the month.

Patients who require complex chronic care management services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, and/or repeat admissions or emergency department visits.Typical adult patients who receive complex chronic care management services are treated with three or more prescription medications and may be receiving other types of therapeutic interventions (eg, physical therapy, occupational therapy). Typical pediatric patients receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy). All patients have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Typical patients have complex diseases and morbidities and, as a result, demonstrate one or more of the following:

- need for the coordination of a number of specialties and services;
- inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver;
- psychiatric and other medical co-morbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care; and/or
- social support requirements or difficulty with access to care.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
99487 (e)		Complex chronic care ~~coordination~~management services, with the following required elements: ▪ multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, ▪ chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, ▪ establishment or substantial revision of a comprehensive care plan, ▪ moderate or high complexity medical decision making; ▪ 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. ~~first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month~~ (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)	XXX	1.00 (No Change)
~~99488~~		~~first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month~~ (99488 has been deleted. To report one or more face-to-face visits by the physician or other qualified health care professional that are		N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		performed in the same month as 99487, use the appropriate E/M code(s).)		
✚ 99489 (e)		each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) (Report 99489 in conjunction with 99487~~, 99488~~) (Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month)	ZZZ	0.50 (No Change)
(Do not report 99487-9948990X during the same month with 90951-90970, 98960-98962, 98966-98969, 99071,99078, 99080, 99090, 99091, 99339, 99340, 99358, 99359, 99363, 99364, 99366-99368, 99374-99380, 99441-99444, 99495, 99496, 99605-99607) *Coding Tip* Time of care ~~coordination~~management with the emergency department is reportable using 99487-994~~89~~90, but time while the patient is inpatient or admitted as observation is not. If the physician personally performs the clinical staff activities, his or her time may be counted toward the required clinical staff time to meet the elements of the code.				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99490 Tracking Number PP1 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.00**
Global Period: XXX RUC Recommended RVU: **1.00**

CPT Descriptor:
Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, Comprehensive care plan established, implemented, revised, or monitored. (Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old man with diabetes, claudication and mild congestive heart failure, status post myocardial infarction with mild dementia who had a peripheral arterial stent placed six weeks ago during a hospitalization for treatment of a foot ulcer. He lives with his daughter, participates in remote monitoring programs and is being treated by two specialists in addition to his primary care physician.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Chronic care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility. These services typically involve clinical staff implementing a care plan directed by the physician or other qualified health care professional when medical and/or psychosocial needs of the patient require establishing and implementing, revising or monitoring the care plan. Services typically include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activities of daily living.
A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social

services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.

The care management office/practice must have the following capabilities:
Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week; provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; provide timely access and management for follow-up after an emergency department visit or facility discharge; utilize an electronic health record system so that care providers have timely access to clinical information; use a standardized methodology to identify patients who require care management services; have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner; use a form and format in the medical record that is standardized within the practice; be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient..

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2014					
Presenter(s):	John Agens, MD (AGS), Thomas Weida, MD (AAFP), Marianna Spinaki, MD, PhD (AAN), Mary Newman, MD (ACP), Joseph Schlecht, DO (AOA), Robert DeMarco, MD (ACCP), Katina Nicolacakis, MD (ATS), Michael Lill, MD, (ASBMT), Phillip Rodgers, MD, Charles Crecelius, MD					
Specialty(s):	American Geriatrics Society (AGS), American Academy of Family Physicians (AAFP), American Academy of Neurology (AAN), American College of Physicians (ACP), American Osteopathic Association (AOA), American College of Chest Physicians (ACCP), American Gastroenterological Association (AGA), American Society of Gastrointestinal Endoscopy (ASGE), American College of Gastroenterology (ACG), American Society of Bone and Marrow Transplantation (ASBMT), and American Thoracic Society (ATS).					
CPT Code:	99490					
Sample Size:	13756	**Resp N:**	338	**Response:** 2.4 %		
Description of Sample:	Random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**25.00**	100.00	3000.00
Survey RVW:	0.00	1.00	**1.50**	2.00	5.25
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	20.00	**30.00**	45.00	240.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99490	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

Select Post-Service Package

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.42	**RUC Time**	9,935,740

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99309	XXX	1.55	**RUC Time**	7,693,411

CPT Descriptor 2 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 101 **% of respondents:** 29.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 99490**	**Key Reference CPT Code:** 99214	**Source of Time RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	0.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**30.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.87	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.10	4.05
Urgency of medical decision making	3.57	3.69
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.65	3.62
Physical effort required	3.11	3.18
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.26	4.15
Outcome depends on the skill and judgment of physician	4.14	4.04

Estimated risk of malpractice suit with poor outcome	3.24	3.22

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.97	3.97
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

There were 338 responses to the survey request. The following societies participated in distributing the survey: American Geriatrics Society (AGS), American Academy of Family Physicians (AAFP), American Academy of Neurology (AAN), American Thoracic Society (ATS), American College of Physicians (ACP), American Osteopathic Association (AOA), American College of Chest Physicians (ACCP), American Gastroenterological Association (AGA), the American Society of Gastrointestinal Endoscopy (ASGE), the American College of Gastroenterology (ACG), and the American Society for Blood and Marrow Transplantation (ASBMT). These societies represent allopathic and osteopathic physicians, nurse practitioners, and physician assistants. The summary tables included with the material submitted by the specialty societies contain total and breakout survey results. With the approval of the Research Subcommittee, the specialty societies modified the survey tool for the purpose of surveying the clinical staff time for the service and the amount of physician time spent performing clinical staff activities.

Background

A multi-specialty and multi-discipline expert panel ("panel") reviewed the survey results and developed the following rationale for the recommended work value for this Chronic Care Management (CCM) code, 99490.

Code 99490 is conceptually similar to code 99487, *Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month*. On November 27, 2013 in the Medicare Physician Fee Schedule Final Rule for Calendar Year 2014, CMS announced that it had decided to create a CCM service effective January 1, 2015, and finalized a proposal to establish a G code to describe the service. In response to this, announcement, a number of specialty societies submitted a coding change proposal to establish a new CPT code for CCM. The proposed code for CCM had the same descriptor as the G code established by CMS. In addition to creating the new CPT code, the CPT Editorial Panel, at their February 2014 meeting, created new introductory language specifically for the new CCM code. CPT decided to retain 99487 and 99489 and to delete 99488, *Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month* (the complex chronic care coordination (CCCC) code that included a face-to-face visit). Most importantly, the CPT structure starting in January 2015 will be as follows: 99487 and 99489 will exist as a family of two codes that, when appropriate, will be used together; 99490 will exist as a separate stand-alone code, in part because CMS declined to establish an add-on code (like 99489) for 99490. Physicians are likely to choose to use 99487/99489 OR 99490 depending on individual payer requirements and policy.
Therefore, it was critically important that 99490 be surveyed on its own, with only the new CPT instructions for 99490 available to respondents. Additionally, codes 99487 and 99489 were not included on the RSL, so the respondents would not confuse the new code with 99487/99489. This is why only the new CPT guideline language for 99490 was included in the survey - and not the guideline language for 99487.

CCM describes non-face-to-face management of a patient, over a calendar month, and requires at least 20 minutes of clinical staff time under the direction of a physician or other qualified health care professional. Because the code requires

"at least 20 minutes of clinical staff time," the surveying specialties decided to survey clinical staff time in addition to physician time and work. Importantly, the specialties heard that, in some cases, physicians are not only directing the service but also acting as clinical staff. Therefore, the specialties also surveyed physician time spent performing clinical staff activities and asked the respondents to separate the time spent directing the service from the time spent performing clinical staff activities (if the respondent performed clinical staff activities). Lastly, the survey specifically requested that the work RVU be based only on the time spent directing CCM - and not on the time spent performing clinical staff activities. Adding these questions allowed the specialties to address some of the concerns raised by the RUC about the survey for 99487, and to make recommendations for: (1) physician time spent directing CCM, (2) physician work spent directing CCM and (3) total clinical staff time (i.e., the sum of clinical staff time as reported in question 2b and physician time spent performing clinical staff activities as reported in question 2c).

In reviewing the survey results, the expert panel kept in mind that 99490 is a stand-alone code that is reported only once no matter how much physician and staff time is spent performing the service, after the minimum of 20 minutes of clinical staff time has been reached. This is not akin to 99487 which had to be valued relative to 99489. The panel agreed that Code 99490 should be valued relative to the combination of 99487/99489, as it is a stand-alone alternative to those codes.
The panel also acknowledged that 99490 does not include physician or clinical staff time or work performed for unrelated activities.

All physician time in the CCM and CCCC codes is considered intra-service time, because it includes all time spent during a calendar month.

Reference Services

For 99490, the key reference service was 99214:

- 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family* with a work RVU of 1.5 and total time of 40 minutes (5/25/10).

The survey median RVU for 99490 was 1.50 with a total physician time of 30 minutes to direct the service; the survey 25th percentile for work was 1.00 and the 25th percentile for time was 20 minutes to direct the service.

Recommendation and Rationale

The multi-specialty expert panel reviewed the survey data and considered the placement of 99490 into proper rank order with 99487 and other non-face-to-face E/M codes.

Code	Description	Work RVU	Intra-service Time	Total Time
99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	1.25	20	40
99340	Individual physician supervision of a patient	1.80	30	60

	(patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more			
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	1.10	30	40
90832	Psychotherapy, 30 minutes with patient and/or family member	1.50	30	45
99203	New Patient Visit	1.42	20	29

The care plan oversight codes 99339 and 99340 are reported for patients who are clinically less complex than patients who receive CCM services. Specifically, there is oversight and management of only a portion of the patient's care, namely the problems that make the patient eligible for home care or hospice care. Care plan oversight entails 30 min of physician time over the course of a month generally limited to the focus of the home or hospice care episode; for example, overseeing the nursing or therapist functions by following patient progress, as reported by those caregivers, and ensuring that the care plan is followed. The oversight includes conversations between healthcare, not family members. Oversight does not include issues such as social support, resolution of psychosocial issues and active management of functional needs. Thus, because family members and caregivers are not part of the service, the work is less stressful and more straightforward.
The team conference codes 99366, 99367 and 99368 are reported for the subset of patient problems that require care coordination - not for all their problems. Team conferences focus on those medical issues being attended to by the team members who attend the conference (e.g., physical therapy, primary care, cardiology, etc.).

The expert panel reviewed 99203 and agreed that 99490 was less intense than 99203 but that the total work was similar given that 99490 has 10 more minutes of intraservice time. The panel noted that 90832 is a focused time limited visit while 99490 addresses many medical, psychosocial and functional activity issues over an entire month.

With respect to the physician work, we believe that 99490, which has a higher intraservice time but lower total service time than code 99214 should have an identical work RVU because the total work is the same even though the total time is less. We also note that the total time spent in directing the clinical staff is in an appropriate ratio to the total clinical staff time (30/60).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) (To Be Determined)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? see attachment If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

Office visit

BETOS Sub-classification Level II:
Established

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99214

Tab 28 RUC Summary CCMS (2p)

ISSUE: Chronic Care Management Service

TAB: 28

Tracking Number	Source	CPT	Short DESC	Resp	IWPUT	RVW					Total Time	PRE	2.a YOUR own time MD/PA/NP supervise					IMMD	SURVEY EXPERIENCE				
						MIN	25th	MED	75th	MAX		EVAL	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
	Key REF	99214	Office visit for the E/M of an established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	101	0.0466			1.50			40	5			25			10					
F1	RUC Rec. 2012	99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month	147	0.0385			1.00			26				26								
F3	RUC Rec. 2012	99489	Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	147	0.0385			0.50			13				13								
PP1	SVY-T	99490	Chronic Care Management Service	338	0.0500	0.00	1.00	1.50	2.00	5.25	30		1	20	30	45	240		0	1	25	100	3000
SVY	AGS	99490	Chronic Care Management Service	135	0.0500	0.00	1.05	1.50	2.03	5.00	30		1	20	30	45	180		0	5	40	120	2000
SVY	AOA	99490	Chronic Care Management Service	55	0.0500	0.00	0.94	1.50	1.80	2.89	30		4	20	30	43	240		0	0	20	55	3000
SVY	ASBMT	99490	Chronic Care Management Service	40	0.0483	0.00	1.00	1.93	2.11	5.25	40		5	25	40	60	180		0	1	25	100	2000
SVY	AAN	99490	Chronic Care Management Service	34	0.0453	0.20	0.76	1.36	1.78	5.00	30		10	21	30	39	120		0	0	10	100	800
SVY	AAFP	99490	Chronic Care Management Service	27	0.0583	0.00	1.30	1.75	2.00	3.00	30		5	20	30	30	200		0	5	20	300	1200
SVY	ACP	99490	Chronic Care Management Service	23	0.0450	0.20	0.90	1.35	1.95	2.50	30		10	20	30	40	90		0	1	10	40	1000
SVY	ACCP & ATS	99490	Chronic Care Management Service	15	0.0500	0.05	1.00	1.50	2.48	3.20	30		10	20	30	40	60		0	2	30	113	500
SVY	AGA-ASGE-ACG	99490	Chronic Care Management Service	9	0.0667	0.10	1.50	2.00	2.00	2.25	30		10	15	30	35	120		3	5	12	60	200
PP1	REC	99490	Chronic Care Management Service	338	0.0333			1.00			30				30								

Tab 28 RUC Summary CCMS (2p)

ISSUE: Chronic Care Management Service

TAB: 28

Tracking Number	Source	CPT	Short DESC	2.b Clinical Staff Time					2.c Clinical Staff time by MD/PA/NP				
				MIN	25th	MED	75th	MAX	MIN	25th	MED	75th	MAX
	Key REF	99214	Office visit for the E/M of an established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.										
F1	RUC Rec. 2012	99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month										
F3	RUC Rec. 2012	99489	Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month										
PP1	SVY-T	99490	Chronic Care Management Service	0	30	45	60	320	0	5	15	30	240
SVY	AGS	99490	Chronic Care Management Service	0	30	45	60	200	0	6	15	25	120
SVY	AOA	99490	Chronic Care Management Service	4	25	40	60	320	0	8	20	30	180
SVY	ASBMT	99490	Chronic Care Management Service	15	35	45	60	200	0	8	23	30	240
SVY	AAN	99490	Chronic Care Management Service	0	20	40	60	120	0	5	10	24	90
SVY	AAFP	99490	Chronic Care Management Service	10	23	45	60	180	0	4	10	15	150
SVY	ACP	99490	Chronic Care Management Service	15	20	30	65	120	0	10	20	27	90
SVY	ACCP & ATS	99490	Chronic Care Management Service	20	25	45	58	150	5	13	20	28	60
SVY	AGA-ASGE-ACG	99490	Chronic Care Management Service	15	30	30	45	240	0	4	15	20	150
PP1	REC	99490	Chronic Care Management Service			60							

Additional Information on Clinical Staff Time for CCM Code 99490

Below is additional information clarifying the amount of time that is spent performing clinical staff activities for 99490. Please review the attached table after reading the below.

The clinical staff time for the other non-face-to-face chronic care management code, 99487, was not surveyed back in 2012 because the descriptor specified "60 minutes" of clinical staff time was required to report 99487. However, the descriptor for 99490 says "***at least 20 minutes of clinical staff time.***" Therefore, the actual staff time is not specified so it was important to survey for "typical" clinical staff time in order to make sure the code was accurately valued for clinical staff time. Two questions regarding the amount of clinical staff time were added to the survey: one for the amount time spent by clinical staff performing clinical staff activities and a second question asking how much physician time was spent performing clinical staff activities. It is important to note that the standard questions for physician work and physician time spent on supervision (which was the time upon which the work RVU was based) were also asked; therefore there were three questions regarding time in this survey: (2 a) asked about physician time spent supervising, (2 b) asked about clinical staff activities performed by clinical staff and (2 c) asked about clinical staff activities performed by the physician.

If you look at the yellow line tracking number PP1 on the *attached table* - that is the response from the entire survey - you can see the median clinical staff time spent by clinical staff is 45 minutes while the median clinical staff time spent by a physician or other mid-level practitioner is 15 minutes. If you add these amounts you get a total of 60 minutes of time spent performing clinical staff activities and this was the request from the specialty societies and the recommendation of the RUC. The RUC heavily considered the subgroup analysis, also included on the attached table, when developing its recommendation.

As support the specialty societies also offered a sub analysis of the data, the green row, titled tracking # 11 which contains only data from 61 physicians who responded that **they did not perform any clinical staff work** (i.e., all clinical staff work was spent by clinical staff meaning that question 2 c was answered as "0"). The median clinical staff time for this group of physicians was 60 minutes, supporting our recommendation for 60 minutes of clinical staff time. If you look at the red row, titled tracking # 12 which contains the responses from those physicians who responded that 1 or more minutes of clinical staff time was performed by a physician or mid-level practitioner, the total time for clinical staff activities is 65 minutes - the sum of the medians of the time spent by clinical staff, 45 minutes, and the time spent by the physician, 20 minutes.

In summary, the survey data, whether analyzed in total or by the pertinent subgroups, supports assignment of 60 minutes of clinical staff time to 99490.

Physician Personally Perform Clinical Activities
vs
Physician Does Not Perform Clinical Activities

ISSUE: Chronic Care Management Service

TAB: 28

Tracking Number	Source	CPT	Short DESC	Survey Resp	Physician Work & Physician Supervision Time: IWPUT	RVW 25th	RVW MED	RVW 75th	Total Time	2.a Physician INTRA time MD/PA/NP supervise clinical staff 25th	2.a MED	2.a 75th	Time Spent Performing Clinical Staff Activities: 2.b Clinical Staff Activities: Time Spent by Clinical Staff MIN	2.b 25th	2.b MED	2.b 75th	2.c Clinical Staff Activities: Time spent by Physician, APN, PA 25th	2.c MED	2.c 75th
PP1	SVY-Total April 2014	99490X	Chronic Care Management Service	338	0.0500	1.00	1.50	2.00	30	20	30	45	0	30	45	60	5	15	30
11	MD (0) Does NOT perform any Clinical	99490X	Chronic Care Management Service	61	0.0500	0.97	1.50	2.00	30	25	30	60	0	30	60	80	0	0	0
12	MD personally performs some of clinical	99490X	Chronic Care Management Service	277	0.0500	1.00	1.50	2.00	30	20	30	45	0	25	45	60	10	20	30
	RUC REC	99490X	Chronic Care Management Service	338	0.0333	1.00			30		30				60			0	

Chronic Care Management Services

Utilization Projections

Projected Number of Medicare Beneficiaries Eligible to Receive CCCC[1/2]									**3,221,481**
	Number of Chronic Conditions	2	3	4	5+	Total			
	Beneficiaries	5,836,109	5,831,371	4,289,659	5,817,468	21,774,607			
	% with Functonal Impairment	9%	10%	14%	26%				
	Number with Functional Impairment	525,250	583,137	600,552	1,512,542	**3,221,481**			
Number of Beneficiaries who will have access to practice that is advanced medical home									
	Measure readiness by review of Primary Care physicians who met Meaningful Use for EMR, Stage 1 [3]						17.8%		
	Multiple this number by two to be conservative as others are adopting EMR/advanced practice models						x 2		
	Percent of Practices Capable (also estimated from practice size/type from HSC Community Tracking Study) [4]						40.0%	**1,288,592**	
Based on Care Plan requirements, potential to report other services (TCM, G0181, etc), estimate # of CCCC per patient/ per year								**6**	
Note: As we observed with Transitional Care Management services, we believe the potential utilization will not be realized in year one, rather would be phased in over multiple years.									
Number of Potential CCCC Codes (99490X) Reported per year								**7,731,554**	

2015 Code	Estimate% Utilization split* between the codes	Distribution between codes (if CMS only approves (1) code this will be the code billed.)	2015 Work RVU	Total Projected Work RVUs	% 99214/99215 Avoided/ Replaced	# of 99214/99215 Avoided/Replaced	99214 Work RVUs Saved (1.50)[5]	99215 Work RVUs Saved (2.11)[5]
99490	**1.00**	7,731,554	1.00	7,731,554	20%	1,546,311	2,087,520	326,272
Total	100%	**7,731,554**		7,731,554			2,087,520	326,272

Projected Additional Work RVUs for 2014 - Offset by Avoided/Replaced Office Visits				**5,317,763**
Projected Required Conversion Factor Offset (without ED/Hospital Offset)	(2014 CF $35.8228)			**$190,497,156**
Assume a 5% reduction in emergency department visits for these patients				
Number of Patients assumed to be qualify and have access to CCCC codes		1,288,592		
Percent of these patients with emergency department visits in year [2]		30%		
Assume 5% of the potential visits would be eliminated due to CCCC service		5%	19,329	
Offset Work RVUs from Avoided Emergency Department Visits [6]				**-$2,287,738**
Assume a 5% reduction in hospitalizations for these patients				
Number of Patients assumed to be qualify and have access to CCCC codes		1,288,592		
Percent of these patients with hospitalizations visits in year [2]		40%		
Assume 5% of the potential hospitalizations would be eliminated due to CCCC service		5%	25,772	
Offset Work RVUs from Avoided Hospitalizations [7]				**-$5,735,964**
Projected Required Conversion Factor Offset (with ED/Hospital Offset)				**$182,473,453**

1 http://www.thescanfoundation.org/sites/thescanfoundation.org/files/1pgdatabrief_no20.pdf

2 http://www.thescanfoundation.org/sites/thescanfoundation.org/files/1pg_databrief_no25.pdf

3 http://www.nejm.org/doi/pdf/10.1056/NEJMc1213481

4 http://www.hschange.com/CONTENT/941/?topic=topic22#ib1

(Practices with 3 or more physicians, including hospital owned outpatient practices / 36% = 9.8+17.6+4.2+12(40%))

5 10% of all 99214 and 99215s billed are at the highest level of 99215 - same ratio utilized in this assumption

6 Use same ratio of overall reporting of 99284 (40%) to 99285 (60%)

7 Assume typical hospitalization would include 1 admission (99222 (40%)/99223 (60%), 1 subsequent hospital visit (99232 (70%)/99233 (30%), and one discharge day 99238)

CPT Code:_99490___
Specialty Society('s)_AAFP, AAN, ACCP, ACG, ACP, AGA, AGS, AOA, ASBMT, ATS__

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:

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

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

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

Global Period:_XXX_ Meeting Date: _April 2014____
NOTE: Services are per patient, per calendar month.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel of experts from the surveying societies met by phone and email to develop the inputs.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code **99487**
Rationale:

We believe this service will utilize a case manager that is an RN, rather than the RN/LPN mix as outlined in the 2014 final rule practice requirement for the CMS "G" code, which is most similar to 99490. The 2014 final rule is correct to identify that the work of the case manager is, at a minimum, at the RN level or higher.

Code 99487 (*Complex chronic care management services with the following required elements;*

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- establishment or substantial revision of a comprehensive care plan,
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

(Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None

Intra-Service Clinical Labor Activities:

Chronic care management activities performed by clinical staff typically include:

- communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family;
- management of care transitions not reported as part of transitional care management (99495, 99496);
- ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M, noted above;
- development, communication, and maintenance of a comprehensive care plan.

Post-Service Clinical Labor Activities:

None

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		REFERENCE CODE			
2	~~*Please note: If a supply has a purchase price of $100 or~~ more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the ***PE Spreadsheet Instructions*** document for an example.			**99214**		**99487** **(Note 2013 Description)**		**99490**	
3	**Meeting Date: April 2014** **Tab: 28** **Specialty: AAFP, AAN, ACCP, ACG, ACP, AGA, AGS, AOA, ASBMT, ATS**	**CMS Code**	**Staff Type**	Office OP visit for the E/M established patient. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes F2F with the patient and/or family.		Complex chronic care coordination services; **first hour of clinical staff time** directed by a physician or other qualified health care professional with no F2F visit, **per calendar month**		Chronic care management services, **at least 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, **per calendar month**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**50.0**	**0.0**	**60.0**	**0.0**	**20.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**41.0**	**0.0**	**60.0**	**0.0**	**20.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**6.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	*Other Clinical Activity - *specify: Review/read X-ray, lab, pathology reports*	L037D	RN/LPN/MTA	**3**					
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	**3**					
22	Obtain vital signs	L037D	RN/LPN/MTA	**5**					
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**					
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	**2**					
27	Sedate/apply anesthesia								
28	*Other Clinical Activity - specify:								
29	**Intra-service**								
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	**5**					
31	Assist physician/moderate sedation (% of physician time)								
32	**Post-Service**								
33	Monitor pt. following moderate sedation								
34	Monitor pt. following service/check tubes, monitors, drains (not related to moderate sedation)								
35	Clean room/equipment by physician staff								
36	Clean Scope								
37	Clean Surgical Instrument Package								
38	Complete diagnostic forms, lab & X-ray requisitions								
39	Review/read X-ray, lab, and pathology reports								
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**11**					
41	*Other Clinical Activity - specify: Review/read X-ray, lab, pathology reports	L037D	RN/LPN/MTA	**13**					

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		REFERENCE CODE			
2	**Please note: If a supply has a purchase price of $100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the *PE Spreadsheet Instructions* document for an example.**			**99214**		**99487 (Note 2013 Description)**		**99490**	
3	**Meeting Date: April 2014 Tab: 28 Specialty: AAFP, AAN, ACCP, ACG, ACP, AGA, AGS, AOA, ASBMT, ATS**	**CMS Code**	**Staff Type**	Office OP visit for the E/M established patient. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes F2F with the patient and/or family.		Complex chronic care coordination services; **first hour of clinical staff time** directed by a physician or other qualified health care professional with no F2F visit, **per calendar month**		Chronic care management services, **at least 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, **per calendar month**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**	
42	*Care management activities performed by clinical staff typically include: communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care; communication with home health agencies and other community services utilized by the patient; collection of health outcomes data and registry documentation; patient and/or family/caregiver education to support self-management, independent living, and activities of daily living; assessment and support for treatment regimen adherence and medication management; identification of available community and health resources; facilitating access to care and services needed by the patient and/or family, management of care transitions not reported as part of transitional care management (99495, 99496), ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M, noted above, development and maintenance of a comprehensive care plan.*	**L037D**	**RN/LPN/MTA**			**60**		**20**	
43	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**	
44	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**	
45	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**	
46	**End: Patient leaves office**								
47	**POST-SERVICE Period**								
48	**Start: Patient leaves office/facility**								
49	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**6**					
58	**End: with last office visit before end of global period**								
59	**MEDICAL SUPPLIES****	**CODE**	**UNIT**						
60	pack, minimum multi-specialty visit	SA048	pack						
61	pack, EM visit	SA047	pack	**1**					
62	**EQUIPMENT**	**CODE**							
63	otoscope-ophthalmoscope (wall unit)	EQ189		**44**					
64	table, exam	EF023		**44**					

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		REFERENCE CODE			
2	*Please note: If a supply has a purchase price of $100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the ***PE Spreadsheet Instructions*** document for an example.			**99214**		**99487** **(Note 2013 Description)**		**99490**	
3	**Meeting Date: April 2014** **Tab: 28** **Specialty: AAFP, AAN, ACCP, ACG, ACP, AGA, AGS, AOA, ASBMT, ATS**	**CMS Code**	**Staff Type**	Office OP visit for the E/M established patient. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes F2F with the patient and/or family.		Complex chronic care coordination services; **first hour of clinical staff time** directed by a physician or other qualified health care professional with no F2F visit, **per calendar month**		Chronic care management services, **at least 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, **per calendar month**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**	
6	**TOTAL CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**50.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**41.0**	**0.0**	**60.0**	**0.0**	**60.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**6.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms								
13	Coordinate pre-surgery services								
14	Schedule space and equipment in facility								
15	Provide pre-service education/obtain consent								
16	Follow-up phone calls & prescriptions								
17	*Other Clinical Activity - *specify: Review/read X-ray, lab, pathology reports*	L037D	RN/LPN/MTA	**3**					
18	**End: When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters office/facility for surgery/procedure:**								
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	**3**					
22	Obtain vital signs	L037D	RN/LPN/MTA	**5**					
23	Provide pre-service education/obtain consent								
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**					
25	Setup scope (non facility setting only)								
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	**2**					
27	Sedate/apply anesthesia								
28	*Other Clinical Activity - specify:								
29	**Intra-service**								
30	Assist physician in performing procedure	L037D	RN/LPN/MTA	**5**					
31	Assist physician/moderate sedation (% of physician time)								
32	**Post-Service**								
33	Monitor pt. following moderate sedation								
34	Monitor pt. following service/check tubes, monitors, drains (not related to moderate sedation)								
35	Clean room/equipment by physician staff								
36	Clean Scope								
37	Clean Surgical Instrument Package								
38	Complete diagnostic forms, lab & X-ray requisitions								
39	Review/read X-ray, lab, and pathology reports								
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**11**					
41	*Other Clinical Activity - specify: Review/read X-ray, lab, pathology reports	L037D	RN/LPN/MTA	**13**					

	A	B	C	D	E	F	G	H	I
1				REFERENCE CODE		REFERENCE CODE			
2	***Please note: If a supply has a purchase price of $100 or more please bold the item name and CMS code. **Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the *PE Spreadsheet Instructions* document for an example.**			**99214**		**99487 (Note 2013 Description)**		**99490**	
3	**Meeting Date: April 2014 Tab: 28 Specialty: AAFP, AAN, ACCP, ACG, ACP, AGA, AGS, AOA, ASBMT, ATS**	**CMS Code**	**Staff Type**	Office OP visit for the E/M established patient. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes F2F with the patient and/or family.		Complex chronic care coordination services; **first hour of clinical staff time** directed by a physician or other qualified health care professional with no F2F visit, **per calendar month**		Chronic care management services, **at least 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, **per calendar month**	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**	
42	*Care management activities performed by clinical staff typically include: communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care; communication with home health agencies and other community services utilized by the patient; collection of health outcomes data and registry documentation; patient and/or family/caregiver education to support self-management, independent living, and activities of daily living; assessment and support for treatment regimen adherence and medication management; identification of available community and health resources; facilitating access to care and services needed by the patient and/or family, management of care transitions not reported as part of transitional care management (99495, 99496), ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M, noted above, development and maintenance of a comprehensive care plan.*	**L051A**	**RN**			**60**		**60**	
43	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**	
44	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**	
45	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**	
46	**End: Patient leaves office**								
47	**POST-SERVICE Period**								
48	**Start: Patient leaves office/facility**								
49	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**6**					
58	**End: with last office visit before end of global period**								
59	**MEDICAL SUPPLIES****	**CODE**	**UNIT**						
60	pack, minimum multi-specialty visit	SA048	pack						
61	pack, EM visit	SA047	pack	**1**					
62	**EQUIPMENT**	**CODE**							
63	otoscope-ophthalmoscope (wall unit)	EQ189		**44**					
64	table, exam	EF023		**44**					

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2017

Chronic Care Management Services

In February 2017, the CPT Editorial Panel created a new code to describe at least 30 minutes of chronic care management services performed personally by the physician or qualified health care professional over one calendar month. This service is different than existing chronic care management services 99490 *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month…*(work RVU = 0.61) and 99487 *Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month* (work RVU = 1.00) which are performed by clinical staff under the supervision of a physician. The patient acuity criteria for all these services are the same but the physician work is different and more intense for 99491. CPT code 99491 cannot be reported with 99490 or 99487 and must capture all the work for the month.

The RUC reviewed the survey results from 153 physicians for CPT code 99491 and determined that the survey 25th percentile of 1.45 work RVUs appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes of intra-service time for 99491. The RUC compared the surveyed code to the top key reference service 99214 (work RVU = 1.50, 25 minutes intra-service time and 40 minutes total time) and determined that the physician work and time for 99491 is slightly less as this is a non face-to-face service. For additional support, the RUC referenced similar service 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 1.42 and 29 minutes total time). **The RUC recommends a work RVU of 1.45 for CPT code 99491.**

Practice Expense
There is a single clinical staff time input for this service, 15 minutes to *Perform procedure/service---NOT directly related to physician work time* and no supplies or equipment. The 15 minutes of time is distributed throughout the month and the clinical staff will typically perform the following tasks during this time:

- Relaying/communicating patient messages,
- Communication with patient and/or pharmacy for prescription refills, prior authorizations or clarifications (assisting physician with paperwork for DME may be included here, or separately)
- Coordination with outside agencies or other providers (i.e. Obtaining referral forms, tracking down documentation of care received outside the primary care office or tracking down results on tests ordered by provider other that the PCP)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

An observer from CMS questioned why the clinical labor staff time is half that of the physician time. The specialty societies indicated that the clinical staff services would include patient maintenance activities such as answering questions, refilling prescriptions and calling home care agencies, that would extend beyond any activities included in other Evaluation and Management services. An additional concern that the description of clinical labor staff work may overlap with the physician work was addressed during the review. The specialty societies indicated that it is possible that in rare cases the requirements for 99490 (20 minutes clinical staff time) and 99491 (30 minutes of physician time) could both be met. However, this would not be the typical case and this situation would only arise if both the physician time and the clinical staff were tracked and documented. If both are tracked and documented then the physician would have the choice as to which code to report. **The RUC recommends that the specialties work with the AMA to develop a CPT Assistant article to clarify the proper reporting of code 99491 versus 99490. The RUC recommends the direct practice expense inputs without modification as submitted by the specialty societies and approved by the Practice Expense Subcommittee.**

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

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Care Management Services** Care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, or may be provided personally by a physician or qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services may include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living. *A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.*				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Codes 99487, 99489, 99490, 99491 are reported only once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month.

For 99490, 99487, and 99489 ~~T~~the face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals, and agencies; revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month. Only the time of the clinical staff of the reporting professional is counted. Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient. For 99491, only count the time personally performed by the physician. Do not count any time of the clinical staff on the day of an initiating visit (the creation of the care plan, initial explanation to patient, and/or caregiver and obtaining consent) ***Note:*** *Do not count any clinical staff time on a day when the physician or qualified health care professional reports an E/M service (office or other outpatient services 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350).*

Care management activities performed by clinical staff, or personally by the physician or other qualified health care professional typically include:

- *communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;*
- *communication with home health agencies and other community services utilized by the patient;*
- *collection of health outcomes data and registry documentation;*
- *patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;*
- *assessment and support for treatment regimen adherence and medication management;*
- *identification of available community and health resources;*
- *facilitating access to care and services needed by the patient and/or family;*
- *management of care transitions not reported as part of transitional care management (99495, 99496);*
- *ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;*
- *development, communication, and maintenance of a comprehensive care plan.*

The care management office/practice must have the following capabilities:

- *provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week;*
- *provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;*
- *provide timely access and management for follow-up after an emergency department visit or facility discharge;*
- *utilize an electronic health record system so that care providers have timely access to clinical information;*
- *use a standardized methodology to identify patients who require care management services;*
- *have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

receiving them in a timely manner;
- *use a form and format in the medical record that is standardized within the practice;*
- *be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.*

E/M services may be reported separately by the same physician or other qualified health care professional during the same calendar month. Care management services include care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (99366, 99367, 99368), education and training (98960, 98961, 98962, 99071, 99078), telephone services (99366, 99367, 99368, 99441, 99442, 99443), on-line medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), transitional care management services (99495, 99496), medication therapy management services (99605, 99606, 99607) and, if performed, these services may not be reported separately during the month for which 99487, 99489, 99490 are reported. All other services may be reported. Do not report 99487, 99489, 99490, 99491 if reporting ESRD services (90951-90970) during the same month. If the care management services are performed within the postoperative period of a reported surgery, the same individual may not report 99487, 99489, 99490, 99491.

Care management may be reported in any calendar month during which the clinical staff time or physician/other qualified health care professional personal time requirements are met. If care management resumes after a discharge during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate. If discharge occurs in the same month, continue the reporting period or report Transitional Care Management Services. Do not report 99487, 99489, 99490 for any post-discharge care management services for any days within 30 days of discharge, if reporting 99495, 99496.

Chronic Care Management Services

Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities. Code 99491 is reported when 30 minutes of physician or other qualified health care professional personal time is spent in care management activities. Do not report 99490 in the same month as 99491.

#99490 *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:*
- *multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;*
- *chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;*
- *comprehensive care plan established, implemented, revised, or monitored.*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)
(Do not report 99490 in the same calendar month as 99487, 99489, 99491)

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●99491	F1	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored (Do not report 99491 in the same calendar month as 99487, 99489, or 99490) (Do not report 99340, 99339 with 99491)	XXX	1.45

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99491 Tracking Number F1 Original Specialty Recommended RVU: **1.85**
Presented Recommended RVU: **1.85**
Global Period: XXX Current Work RVU: **N/A** RUC Recommended RVU: **1.45**

CPT Descriptor: Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored / / (Do not report 99491 in the same calendar month as 99487, 99489, or 99490) / (Do not report 99340, 99339 with 994X7)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
(adult) An 83-year-old woman with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program and sees a cardiologist and neurologist.

(child) A 6-year-old child with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airway disease, chronic seizure disorder, failure to thrive and severe neurodevelopment delay. He receives home occupational, physical and speech therapy services.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: These chronic care management services are management (CCM) and support services personally provided by a physician or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services typically include establishing, implementing, revising, or monitoring the care plan; coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides and or oversees the coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.
A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community and social services ordered, how the services of agencies and specialists unconnected to the practice will be directed and coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.

The care management office/practice must have the following capabilities:

Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients and caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week; provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; provide timely access and management for follow up after an emergency department visit or facility discharge; utilize an electronic health record system so that care providers have timely access to clinical information; use a standardized methodology to identify patients who require care management services; have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner; use a form and format in the medical record that is standardized within the practice; be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2017		
Presenter(s):	John Agens, MD, Jennifer Aloff, MD, Kevin Kerber, MD, Mary Newman MD		
Specialty(s):	American Academy of Neurology, American College of Physicians, American Academy of Family Physicians and American Geriatrics Society		
CPT Code:	99491		
Sample Size:	8918	**Resp N:** 153	**Response:** 1.7 %
Description of Sample:	All societies selected 1000 to 2000 randomly selected members for this survey.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**10.00**	45.00	2592.00
Survey RVW:	0.00	1.45	**1.85**	2.30	100.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	20.00	**30.00**	45.00	158.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99491	**Recommended Physician Work RVU: 1.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.11	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.50	**RUC Time**	95,554,488

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.11	**RUC Time**	9,446,476

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
99495	XXX	2.11	**RUC Time**

CPT Descriptor Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 36 **% of respondents:** 23.5 **%**

Number of respondents who choose 2nd Key Reference Code: 35 **% of respondents:** 22.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 99491	**Top Key Reference CPT Code:** 99214	**2nd Key Reference CPT Code:** **99215**
Median Pre-Service Time	0.00	5.00	5.00
Median Intra-Service Time	30.00	25.00	35.00
Median Immediate Post-service Time	0.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**40.00**	**55.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**

Overall intensity/complexity	0%	6%	36%	50%	8%

Mental Effort and Judgment	**Less**	**Identical**	**More**
The number of possible diagnosis and/or the number of management options that must be considered	22%	36%	42%
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	6%	33%	61%
Urgency of medical decision making	31%	47%	22%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	11%	67%	22%
Physical effort required	8%	72%	19%

Psychological Stress	**Less**	**Identical**	**More**
The risk of significant complications, morbidity and/or mortality	3%	44%	53%
Outcome depends on the skill and judgment of physician	3%	56%	42%
Estimated risk of malpractice suit with poor outcome	31%	50%	19%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	11%	31%	49%	9%

Mental Effort and Judgment	**Less**	**Identical**	**More**
The number of possible diagnosis and/or the number of management options that must be considered	14%	40%	46%
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	6%	51%	43%
Urgency of medical decision making	23%	43%	34%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	6%	60%	34%
Physical effort required	3%	63%	34%

Psychological Stress	Less	Identical	More
The risk of significant complications, morbidity and/or mortality	9%	29%	63%
Outcome depends on the skill and judgment of physician	3%	46%	51%
Estimated risk of malpractice suit with poor outcome	0%	40%	37%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The American Geriatrics Society (AGS), American College of Physicians (ACP), American Academy of Family Physicians (AAFP), and the American Academy of Neurology (AAN) conducted joint random surveys of their memberships in March 2017 for CPT code 99491. A joint AGS, ACP, AAFP, and AAN RVS expert panel ("joint panel") consisting of physician advisors reviewed the survey work and time data and developed recommendations through participation in conference calls and e-mail discussions.
There were 153 responses (65 geriatricians, 24 internists, 10 family physicians, 50 neurologists, 4 other identified in other, as pediatric, endocrinologists or cardiologists) to the survey request with a median performance rate of 10; 93% of the survey respondents found the vignette to be typical. The RUC summary contains a breakout of medical specialty self-identified by the respondents. The number of responses meet RUC criteria and the majority of respondents perform this service.
The two key reference services were 99214 (36 responses) and 99215 (35 responses). The joint panel agreed that this even split in the two most common reference services chosen indicates that the recommended RVW for 99491 should be in-between that of 99214 and 99215. In addition, while 99487 was not one of the most commonly chosen reference services, the joint panel kept in mind that 99491 is the physician work equivalent of 99487 (Complex chronic care management services with clinical staff time of 60 minutes) and that it is important that the physician time and RVW for 99491 and 99487 also be in proper rank order. The joint panel also kept in mind the required elements for 99491 which are:

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

The joint panel also noted that this service does not include any pre and post service time, because it describes care furnished over a calendar month. Therefore, the reliability of the intra-service time data is critical to appropriately valuing the service.
After agreeing on these initial considerations, the joint panel reviewed the survey results, the times and RVWs of the two major reference services and other related E/M services.

First, the joint panel reviewed the survey results. The median times for all specialties was similar and among the three specialties with the most respondents was 28, 30, and 31 minutes. For respondents who chose 99214 as the key reference service, the median survey code time was 30 minutes and for respondents who chose 99215, the median survey code times was 35 minutes. The distribution was normal across all specialties. The joint panel concluded that the time data was reliable.

The median work RVW varied among specialties but the distribution was normal for each specialty and for the aggregate. The panel then looked at the data for respondents who chose 99214 as the key reference service. Those respondents had a median RVW of 1.51 and the 25th percentile RVW was 1.50. For respondents who chose 99215 as the key reference service, the median RVW was 2.11 and the 25th percentile RVW was 2.05. The panel noted this very tight distribution felt that the survey median of 1.85 fell almost exactly in the middle of these two groups and had significant face validity.

The joint panel then reviewed the times and RVWs of 99214 and 99215. 99214 has an RVW of 1.5 and times of 5/25/10/40 and 99215 has an RVW of 2.11 and times of 5/35/15/55. In connection with comparing 99491 to 99214 and 99215, the joint panel noted that while 994X7 has no specific requirement for level of medical decision-making, 99214 requires moderate complexity medical decision making and 99215 requires high complexity medical decision making. Based on the survey data and the split choice of 99214 and 99215 as key reference services, the joint panel believes it likely that half the services described by 994X7 require highly complex medical decision making and half require moderately complex medical decision making and that this is clearly reflected by the survey median RVW of 1.85.

The joint panel also noted the survey median intensity/complexity measures indicate that the respondents believe that 99491 is more intense/complex than both 99214 and 99215. The joint panel agreed that even though the total time for 99491 is less than the total times for 99214 and 99215, that all the time is intra-service, that the median time for 99491 is 5 minutes longer than the intra-service time for 99214 and the higher intensity/complexity measures support the median survey RVW. Furthermore, the median RVWs for respondents who chose 99214 or 99215 as the key reference service was practically identical to the reference service chosen and the survey median RVW of 1.85 is almost exactly between the 99214 and 99215 RVWs of 1.5 and 2.11. In addition, the joint panel agreed that the 25th percentile RVW of 1.45 was too low and undervalued the service.

In addition, the panel reviewed 99487 which has 26 minutes of intra-time and an RVW of 1.0 and is much less intense than 994X7 because the physician work for 99487 is entirely supervision of clinical staff and the work of 99491 is entirely direct patient care.

The joint panel also reviewed a number of other services:

- The transitions of care management (TCM) codes, 99495, RVW 2.11 with an intra-service (and total) time of 40 minutes, and 99496, RVW 3.05 and intra-service (and total) time of 50 minutes and agreed that the shorter median time of 30 minutes and the median RVW of 1.85 place 99491 in proper rank order with those codes
- 70496 (CTA Head) and 70498 (CTA Neck) both with times of 5/20/5/30 and an RVW of 1.75 that were RUC reviewed in 2014
- 70552 (MRI Brain Stem w contrast) with times of 5/20/7/32 and an RVW of1.78 that was RUC reviewed in 2013
- 74176 (CT Abdomen and Pelvis w/o contrast) that has times of 5/22/5 and an RVW of 1.74 that is an MPC code and RUC reviewed in 2010.

The joint panel agreed that the greater intensity of 994X7 as compared to the imaging services supported the survey median RVW.

Recommendations

In summary, for 99491 tracking number F1 **we recommend the median RVW of 1.85 of and the median intra-service time of 30 minutes.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Family Practice How often? Sometimes

Specialty Geriatrcians How often? Sometimes

Specialty GP/Internal Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 400000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. In terms of utilization – Medicare utilization for the new code is expected to be 10% of 99490 and that total utilization will be double that. The total 2016 utilization for 99490 was 2,260,521 (according to the RUC database). Therefore we estimate a total of 200,000 Medicare and 400,000 all payers.

Specialty Family Practice Frequency 100000 Percentage 25.00 %

Specialty Geriatrcians Frequency 100000 Percentage 25.00 %

Specialty GP/Internal Medicine Frequency 100000 Percentage 25.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 200,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. In terms of utilization – Medicare utilization for the new code is expected to be 10% of 99490 and that total utilization will be double that. The total 2016 utilization for 99490 was 2,260,521 (according to the RUC database). Therefore we estimate a total of 200,000 Medicare and 400,000 all payers.

Specialty Family Practice Frequency 50000 Percentage 25.00 %

Specialty Geriatrcians Frequency 50000 Percentage 25.00 %

Specialty GP/Internal Medicine Frequency 50000 Percentage 25.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99214

ISSUE: Complex Chronic Care Management by Physician or QHP
TAB: 9

Percent Vig Typica	Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
24%	REF 1	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate	36	0.047	1.5					40	5	25					10					
23%	REF 2	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided	35	0.047	2.11					55	5	35					15					
93%	SVY Total	99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored / / (Do not report 994X7 in the same calendar month as 99487, 99489, or 99490) / (Do not report 99340, 99339 with 994X7)	153	0.062	0.00	1.45	1.85	2.30	100.00	30		0	20	30	45	158		0	1	10	45	2592
100%	Family Medicine	99491	CCM provided personally by a physician / QHP	10	0.051	1.20	1.50	1.78	2.00	20.00	35		15	30	35	39	80		0	3	8	19	2400
100%	Internal Medicine/GP	99491	CCM provided personally by a physician / QHP	24	0.058	0.00	1.28	1.60	2.50	100.00	27.5		6	20	28	39	60		0	1	8	60	1100
100%	Geriatrics	99491	CCM provided personally by a physician / QHP	65	0.067	0.00	1.50	2.00	2.50	100.00	30		0	20	30	45	158		0	1	15	50	2000
82%	Neurology	99491	CCM provided personally by a physician / QHP	50	0.054	0.50	1.44	1.67	2.11	5.20	31		1	22	31	47	120		0	0	4	40	2592
75%	Other: Pediatric/ Endocrinology	99491	CCM provided personally by a physician / QHP	4	0.060	1.00	1.60	2.00	5.40	15.00	34		10	25	34	39	43		3	8	13	16	320
	REC	99491	CCM provided personally by a physician / QHP		0.048	1.45					30				30								

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:
99491 Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored / / (Do not report 994X7 in the same calendar month as 99487, 99489, or 99490) / (Do not report 99340, 99339 with 994X7)

Global Period: XXX Meeting Date: April 2017

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
RUC advisors from all of the participating specialty societies acted as an expert panel and met by conference call to arrive at the recommendations for direct practice expense inputs.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We chose to compare to similar services with varying times, the major difference is that the new code 994X7 is unlike the three below in that a major portion of the work is done by the physician. This does not mean that all work is done by physician, there is still work necessary by clinical staff.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

99487 Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.;

99489 Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

3. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

4. Please provide rationale for the minutes you are recommending for clinical activities that do not have PE Subcommittee standards:

5. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Spreadsheet Update Workgroup and listed in tab 2, please explain the difference here:

7. Please describe in detail the clinical activities of your staff below:

Pre-Service Period Clinical Activities:

Service Period Clinical Activities:

Intra-Service (of Service Period): ***(Service Period is Calendar Month for this 994X7)***

The clinical staff perform the following tasks over the month the service is furnished:

- Call(s) in or email prescription(s)
- communicate with the patient or caregiver if the physician is not available
- receive, review and send tests results and other clinical information to and from other care givers
- schedule appointment(s) with other healthcare providers and outside agencies
- take call(s) from patient or contact patient when MD available for call

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

Detail breakout of Intra-service Clinical Staff:

Five minutes per month in relaying/communicating patient messages,
five minutes in communication with patient and/or pharmacy for prescription refills, prior authorizations or clarifications (assisting physician with paperwork for DME may be included here, or separately)
and five minutes for coordination with outside agencies or other providers (i.e. Obtaining referral forms, tracking down documentation of care received outside the primary care office or tracking down results on tests ordered by provider other that the PCP for a total time of 15 minutes.

9. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

16. If there is any other item on your spreadsheet that needs further explanation please include here:

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:
99491 Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored / / (Do not report 994X7 in the same calendar month as 99487, 99489, or 99490) / (Do not report 99340, 99339 with 994X7)

Global Period: XXX Meeting Date: April 2017

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
RUC advisors from all the participating specialty societies acted as an expert panel and met by conference call to arrive at the recommendations for direct practice expense inputs.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We chose to compare to similar services with varying times, the major difference is that the new code 994X7 is unlike the three below in that a major portion of the work is done by the physician. This does not mean that all work is done by physician, there is still work necessary by clinical staff.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

99487 Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.;

99489 Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

3. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

4. Please provide rationale for the minutes you are recommending for clinical activities that do not have PE Subcommittee standards:

5. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Spreadsheet Update Workgroup and listed in tab 2, please explain the difference here:

7. Please describe in detail the clinical activities of your staff below:

Intra-Service (of Service Period): ***(Service Period is Calendar Month for this 994X7)***

The clinical staff perform the following tasks over the month the service is furnished:

- Call(s) in or email prescription(s)
- communicate with the patient or caregiver if the physician is not available
- receive, review and send tests results and other clinical information to and from other care givers
- schedule appointment(s) with other healthcare providers and outside agencies
- take call(s) from patient or contact patient when MD available for call

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

Detail breakout of Intra-service Clinical Staff:

Five minutes per month in relaying/communicating patient messages,
five minutes in communication with patient and/or pharmacy for prescription refills, prior authorizations or clarifications (assisting physician with paperwork for DME may be included here, or separately)
and five minutes for coordination with outside agencies or other providers (i.e. Obtaining referral forms, tracking down documentation of care received outside the primary care office or tracking down results on tests ordered by provider other that the PCP for a total time of 15 minutes.

9. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

16. If there is any other item on your spreadsheet that needs further explanation please include here:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**REFERENCE CODE**		**REFERENCE CODE**		**REFERENCE CODE**		**RECOMMENDED**	
2		**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.* **Please do not modify formulas in gray shaded cells*				**G0181**		**99490**		**99487**		**99489**		**99491**	
3		***RUC Collaboration Website***													
4	**Clinical Activity Code**	**Meeting Date: April 2017** **Tab: 9** **Specialty: AGS, AAFP, ACP, AAN**	**Standards/Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not		Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care		Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions		Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions		Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care	
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**	**ZZZ**	**XXX**	**XXX**
7		**TOTAL CLINICAL STAFF TIME**		**L037D**	RN/LPN/MTA	**36.0**	**0.0**	**20.0**	**20.0**	**60.0**	**60.0**	**30.0**	**30.0**	**15.0**	**15.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		**L037D**	RN/LPN/MTA	**18.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		**L037D**	RN/LPN/MTA	**18.0**	**0.0**	**20.0**	**20.0**	**60.0**	**60.0**	**30.0**	**30.0**	**15.0**	**15.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		**L037D**	RN/LPN/MTA	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**PRE-SERVICE PERIOD**													
12		**Start: Following visit when decision for surgery or procedure made**													
13	CA001	Complete pre-service diagnostic and referral forms	90 DAY: NF5, F5, 000/10 DAY: NF0, F0* **See Instructions for extensive/minimal use guidelines*	L037D	RN/LPN/MTA	3									
14	CA002	Coordinate pre-surgery services (including test results)	90 DAY: NF10, F20, 000/10 DAY: NF0, F0* **See Instructions for extensive/minimal use guidelines*	L037D	RN/LPN/MTA										
15	CA003	Schedule space and equipment in facility	90 DAY: NF0, F8, 000/10 DAY: NF0, F0* **See Instructions for extensive/minimal use guidelines*	L037D	RN/LPN/MTA										
16	CA004	Provide pre-service education/obtain consent	90 DAY: NF10, F20, 000/10 DAY: NF0, F0* **See Instructions for extensive/minimal use guidelines*	L037D	RN/LPN/MTA										
17	CA005	Complete pre-procedure phone calls and prescription	90 DAY: NF10, F7, 000/10 DAY: NF0, F0* **See Instructions for extensive/minimal use guidelines*	L037D	RN/LPN/MTA										
18	CA006	Confirm availability of prior images/studies	Standard time for this activity is 2 minutes. For use in imaging services.	L037D	RN/LPN/MTA										
19	CA007	Review patient clinical extant information and questionnaire	Standard time for this activity is 1 minute. For use in imaging services.	L037D	RN/LPN/MTA										
20	CA008	Perform regulatory mandated quality assurance activity (pre-service)	This is NOT standard. Rationale must be included on PE SOR.	L037D	RN/LPN/MTA	15									
27		**End: When patient enters office/facility for surgery/procedure**													
28		**SERVICE PERIOD**													
29		**Start: When patient enters office/facility for surgery/procedure:**													
30		**Pre-Service (of service period)**													
46		**Intra-service (of service period)**													
47	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100% of physician intra-service time)	This is NOT standard	L037D	RN/LPN/MTA										
48	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67% of physician intra-service time)	This is NOT standard	L037D	RN/LPN/MTA										
49	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other% of physician intra-service time)	This is NOT standard Percentage must be included on PE SOR	L037D	RN/LPN/MTA										
50	CA021	Perform procedure/service---NOT directly related to physician work time	This is NOT standard	L037D	RN/LPN/MTA	18	0	20	20					15	15
51	CA021	Perform procedure/service---NOT directly related to physician work time	This is NOT standard	L051A	RN					60	60	30	30		
57		**Post-Service (of service period)**													
79		**End: Patient leaves office**													
80		**POST-SERVICE PERIOD**													
81		**Start: Patient leaves office/facility**													
97		**End: with last office visit before end of global period**													
98	**Medical Supply Code**	**MEDICAL SUPPLIES**		**PRICE**	**UNIT**										
99	SA048	pack, minimum multi-specialty visit		1.143	pack	0	0	0	0	0	0	0	0	0	0
105		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*													
106	**Equipment Code**	**EQUIPMENT**	Please select the equipment formula you intend to use for each equipment item from the dropdown list in column E under equipment. If you select "Other formula" please explain in PE SoR. You must also include an excel formula adding the equipment minutes used in columns J and K (this will not be automatic). Please see key in equipment tab for clinical activities included in each equipment formula.	**PRICE**	**EQUIPMENT FORMULA**										
107	EF023	table, exam		1338.17		0	0	0	0	0	0	0	0	0	0
113		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*													

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2012

Complex Chronic Care Coordination Services

In response to the July 2011 Notice of Proposed Rulemaking, the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee created the Chronic Care Coordination Workgroup (C3W) to specifically address the Centers for Medicare and Medicaid Services request to ensure that care coordination services were described and valued within the Evaluation and Management services. The C3W requested that CPT consider creation of codes to describe transitional care management and monthly complex chronic care coordination services. In May 2012, the CPT Editorial Panel created three new codes to describe complex chronic care coordination services that are patient centered management and support services. These services are provided by physicians and, other qualified health care professionals to an individual who resides at home or in a domiciliary, rest home or assisted living facility, per calendar month.

Complex chronic care coordination (CCCC) services are provided to patients who typically have multiple co-morbidities and frequently, multiple medications requiring ongoing non face-to-face care coordination, the choice of code is driven by the clinical staff time over the period of a calendar month. Unlike transitional care management (TCM) services, a recent hospital discharge is not required, but the typical patient has several chronic conditions, sees multiple care providers, requires a variety of therapeutic and diagnostic services and has a management plan that requires frequent revisions. While the goal of TCM is to prevent re-hospitalization, the goal of CCCC is broader. The goals are to efficiently integrate care, maximize the patient's potential function and well-being and prevent hospitalization.

CPT code 99487 is reported for CCCC when there is no face-to-face visit during the calendar month. CPT Code 99488 is reported for CCCC when there is a face-to-face visit during the calendar month. Both CPT codes 99487 and 99488 specify 60 minutes of clinical staff time in the descriptor. Lastly, CPT code 99489 is an add-on code for each additional 30 minutes of clinical staff time for non face-to-face CCCC, which is reported with either codes 99487 or 99488.

CCCC codes 99487, 99488 and 99489 have an XXX global period. All physician and staff time appear in the intra-service time because any services provided during the 30 day service period are, by definition intra-service time. The CPT introductory language specifically describes the physician and clinical staff activities included in these services.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

99487 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

The RUC reviewed the survey results from 147 multi-specialty physicians and other qualified health care professionals for CPT code 99487. In order to maintain the proper rank order in relation to 99488 (described below), the specialty society indicated and the RUC agreed that the survey 25th percentile work RVU of 1.00 and 25th percentile time of 26 minutes are more accurate than the median survey results. The 25th percentile time also placed this service in the proper ratio compared to the clinical staff time of 60 minutes. The RUC compared 99487 to 99367 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician* (work RVU = 1.10 and 40 minutes total time) and determined that 99487 is slightly more intense to perform. The RUC compared 99487 to GXXXX3 *Coordination of care across all of a patient's healthcare needs, provided in a Tier 3 medical home, per month* (RUC Recommended work RVU = 0.35 for 9.2 minutes of service; or a weighted work RVU per minute of .0382) and determined that the work, time and intensity are almost identical, therefore computing a work RVU of 1.00. **The RUC recommends a work RVU of 1.00 and 26 minutes intra-service time for CPT code 99487.**

99488 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

The RUC reviewed the survey results from 147 multi-specialty physicians and other qualified health care professionals for CPT code 99488. The RUC agreed with the survey respondents that the Evaluation and Management service that is most similar to the face-to-face portion of the CCCC service is 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11, 35 minutes intra-time, 55 minutes total time). CPT Code 99215 is used as a proxy to understand the complexity of the patient receiving the service. The RUC understands that the time of the face-to-face portion of this service may be different from that of a typical 99215. The RUC agreed that the survey median work RVU of 2.50 and 60 minutes of intra-service time appropriately accounts for the work required to perform this office visit and the 30 days of complex chronic care coordination services of CPT code 99488.

The RUC compared CPT code 99488 to the key reference service 99350 *Home visit for the evaluation and management of an established patient* (work RVU = 3.28 and 75 minutes intra-service time) and determined that the work and time required to perform the reference service is higher due to higher intra-service time. The RUC compared the service to 99496 *Transitional Care Management services with high medical decision complexity; face-to-face visit within 7 days* (RUC recommended work RVU = 3.05 and 60 minutes intra-service time), also reviewed at this meeting. The RUC determined that the physician work required to perform 99488 is less intense than 99496 for two reasons: (1) the CCCC codes require moderate or highly complex medical decision making, whereas 99496 TCM, 7 days only requires highly complex medical decision making and (2) the patient's condition is well known to the physician due to ongoing CCCC. In the case of TCM codes, the patient's condition post-discharge is not known to the physician, making the patient similar to a new patient.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC compared the 60 minutes median intra-service time in relation to the 107 minutes of total clinical staff time and determined that was appropriate. The RUC assumed the face-to-face portion of this service requires approximately 35 minutes, the same as 99215, which allows 25 minutes to perform the non face-to-face care over the calendar month.

To support the median work RVU of 2.50 and intra-service time of 60 minutes, the RUC compared 99488 to the services listed below, which require similar work, time and intensity. The relativity between code 99488 and these services is appropriate. **The RUC recommends a work RVU of 2.50 and 60 minutes of intra-service time for CPT code 99488.**

CPT Code	Descriptor	Pre-time	Intra-time	Post-time	Work RVU
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	5	45	7	2.50
95954	Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test)	5	60	5	2.45
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components	15	45	17	2.63
90947	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription	10	50	10	2.52
99488	**CCCC services; first hour of clinical staff time one face-to-face visit, per calendar month**		**60**		**2.50**

99489 Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 147 multi-specialty physicians and other qualified health care professionals for CPT code 99489. In order to maintain the proper rank order in relation to 99487, the specialty society indicated, and the RUC agreed, that 99489 is half of the physician work and time. A work RVU of 0.50 and 13 minutes intra-service time place this service in the proper ratio compared to the clinical staff time of 30 minutes. The RUC compared 99489 to GXXXX3 *Coordination of care across all of a patient's healthcare needs, provided in a Tier 3 medical home, per month* (RUC Recommended work RVU = 0.35 for 9.2 minutes of service; or a weighted work RVU per minute of .0382) and determined that the work, time and intensity are almost identical, therefore computing a work RVU of 0.50. The RUC also compared 99489 to 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.48 and 10 minutes intra-service time) and determined that the work, time and intensity maintain the appropriate relativity. **The RUC recommends a work RVU of 0.50 and 13 minutes intra-service time for CPT code 99489.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

2013 Utilization Estimates:
The specialty societies indicated that the estimated utilization for these services will be approximately 9 million per year, representing 10% of all moderate to high complexity established office visits (99214 and 99215). The specialties also estimate that 55% of the CCCC services will be managed without a face-to-face visit using the code 99487. The estimates are projected to be: CPT code 99487 = 5,003,744, code 99488 = 3,730,064, and code 99489 = 363,909. It is estimated that fewer than 5% of patients will require in excess of 60 minutes of nurse manager non face-to-face time in one calendar month. The attached spreadsheet explains the methodology used by the specialty societies to arrive at these assumptions.

New Technology/New Services List:
The specialty society requests and the RUC agrees that CPT codes 99487, 99488, 99489 should be added to the new technology/new services list.

Practice Expense:
The RUC reviewed the direct practice expense inputs and accepted the changes as modified by the Practice Expense Subcommittee. Specifically, any duplication between the clinical staff pre and post service time of the Evaluation/Management Service and the care coordination time was removed from the recommendations. The RUC also understands that electronic medical record systems are considered to be indirect costs and, therefore, these costs are not included in the direct cost recommendations.

Complex Chronic Care Coordination Services

Complex chronic care coordination services are patient centered management and support services provided by physicians, other qualified health care professionals and clinical staff to an individual who resides at home or in a domiciliary, rest home or assisted living facility. These services typically involve clinical staff implementing a care plan directed by the physician or other qualified health care professional. These services address the coordination of care by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activities of daily living.

Patients who require complex chronic care coordination services may be identified by algorithms that utilize reported conditions and services (eg, predictive modeling risk score or repeat admissions or emergency department use) or by clinician judgment. Typical patients have 1 or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. Patients may have medical and psychiatric behavioral co-morbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care. Social support weaknesses or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are expected. Medical decision making as defined in the Evaluation and Management (E/M) guidelines is not only applied to the face-to-face services, but is determined by the nature of the problems addressed by the reporting individual during the month. A plan of care should be documented and shared with the patient and/or caregiver.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Codes 99487-99489 are reported only **once** per calendar month and include all non-face-to-face complex chronic care coordination services and none or 1 face-to-face office or other outpatient, home, or domiciliary visit. Codes 99487-99489 may only be reported by the single physician or other qualified health care professional who assumes the care coordination role with a particular patient for the calendar month.

Code selection is as follows:

99487 is reported when, during the calendar month, there is no face-to-face visit with the physician or other qualified health care professional and at least 31 minutes of clinical staff time is spent in care coordination activities. Code 99488 is reported when, during the calendar month, there is a face-to-face visit with the physician or other qualified health care professional and at least 31 minutes of clinical staff time is spent in care coordination activities.

The face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals and agencies; revising, documenting and implementing the care plan; or teaching self management is used in determining the complex chronic care coordination clinical staff time for the month. **Note**: Do not count any clinical staff time on the date of the first visit or on a day when the physician or qualified health care professional reports an E/M service (office or other outpatient services 99211-99215, domiciliary, rest home services 99334-99337, home services 99347-99350).
Care coordination activities performed by clinical staff may include:

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family;
- development and maintenance of a comprehensive care plan.

If a face-to-face visit was provided during the month by the physician or other qualified health care professional, report 99488. Additional E/M services beyond the first visit may be reported separately by the same physician or other qualified health care professional during the same calendar month. Complex care coordination services include care plan oversight services (99339, 99340, 99374-99378), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (98966-98968, 99441-99443), on-line medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), transitional care management services (99495, 99496), medication therapy management services (99605-99607), and if performed, these services may not be reported separately during the month for which 99487-99489 are reported. All other services may be reported. Do not report 99487-99489 if reporting ESRD services (90951-90970) during the same month. If the complex chronic care coordination services are performed within the postoperative period of a reported surgery, the same individual may not report 99487-99489.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Complex chronic care coordination can be reported in any calendar month during which the clinical staff time requirements are met. If care coordination resumes after a discharge during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate. If discharge occurs in the same month, continue the reporting period or report transitional care management services. Do not report 99487-99489 for any post-discharge complex chronic care coordination services for any days within 30 days of discharge, if reporting 99495, 99496.

Total Duration of Staff Care Coordination Services	**Code(s)**
Less than 30 minutes	Not reported separately
31 to 74 minutes (31 minutes-1 hr. 14 min)	99487 or 99488 X 1
75-104 minutes (1 hr. 15 min- 1 hr. 44 min)	99487 or 99488 X 1 and 99489 X 1
105 minutes or more (1 hr. 45 min. or more)	99487 or 99488 X 1 and 99489 X 2 or more for each additional 30 minutes

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommend-ation
●99487	F1	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month	XXX	1.00
●99488	F2	first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month	XXX	2.50
●99489	F3	each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) (Report 99489 in conjunction with 99487, 99488) (Do not report 99487-99489 during the same month with 90951-90970, 98960-98962, 98966-98969, 99071, 99078, 99080, 99090, 99091, 99339, 99340, 99358, 99359, 99363, 99364, 99366-99368, 99374-99378, 99441-99444, 99495, 99496, 99605-99607)	ZZZ	0.50

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99487 Tracking Number F1 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.00**
Global Period: XXX RUC Recommended RVU: **1.00**

CPT Descriptor:
Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
Typical Patient (99487) (Child)
A 6-year-old child with spastic quadriplegia, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airway disease, chronic seizure disorder, failure to thrive and severe neurodevelopment delay. He receives home occupational, physical and speech therapy services.
Typical patient (99487) (Adult)
An 83-year-old woman with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program and sees a cardiologist and neurologist.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work:
Complex chronic care coordination services are patient centered management and support services provided by physicians, other qualified health care professionals and clinical staff to an individual who resides at home or in a domiciliary, rest home or assisted living facility. These services typically involve clinical staff implementing a care plan directed by the physician or other qualified health care professional. These services address the coordination of care by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activities of daily living.
Patients who require complex chronic care coordination services may be identified by algorithms that utilize reported conditions and services (eg, predictive modeling risk score or repeat admissions or emergency department use) or by clinician judgment. Typical patients have 1 or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute

exacerbation/decompensation or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. Patients may have medical and psychiatric behavioral co-morbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care. Social support weaknesses or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are expected. Medical decision making as defined in the Evaluation and Management (E/M) guidelines is not only applied to the face-to-face services, but is determined by the nature of the problems addressed by the reporting individual during the month. A plan of care should be documented and shared with the patient and/or caregiver.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2012		
Presenter(s):	Robert Zorowitz, MD (AGS), Thomas Weida (AAFP), Mary Newman, MD (ACP), Eileen Carlson, RN, JD (ANA), Steven Krug, MD (AAP) and Joel Brill, MD (AGA).		
Specialty(s):	American Geriatrics Society (AGS), American Academy of Pediatrics (AAP), American College of Cardiologists (ACC), American Academy of Family Physicians (AAFP), American Academy of Neurology (AAN), American Thoracic Society (ATS), American Association of Clinical Endocrinologists (AACE), American College of Rheumatology (ACR), American College of Physicians (ACP), American Osteopathic Association (AOA), American College of Chest Physicians (ACCP), American Academy of Family Physicians (AAFP), American Nursing Association (ANA), American Academy of Physician Assistants (AAPA), American Gastroenterological Association (AGA), The Endocrine Society (TES) and the American Society of Gastrointestinal Endoscopy (ASGE).		
CPT Code:	99487		
Sample Size:	8896	**Resp N:** 147	**Response:** 1.6 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**10.00**	35.00	3000.00
Survey RVW:	0.00	1.00	**1.50**	2.00	25.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	26.00	**45.00**	60.00	600.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	99487	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**26.00**		
Immediate Post Service-Time:	**0.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		

Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99374	XXX	1.10	**RUC Time**

CPT Descriptor Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.50	**CMS Time File**	81,311,416

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93281	XXX	0.90	**RUC Time**

CPT Descriptor Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 38 **% of respondents:** 25.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 99487**	**Key Reference CPT Code:** 99374	**Source of Time RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	26.00	20.00	
Median Immediate Post-service Time	0.00	9.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**26.00**	**34.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.66	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.79
Urgency of medical decision making	3.34	3.42
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.24	3.26
Physical effort required	3.00	3.13
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.79	3.76
Outcome depends on the skill and judgment of physician	3.92	3.76
Estimated risk of malpractice suit with poor outcome	3.37	3.41

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		

Intra-Service intensity/complexity	3.61	3.55
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Complex Chronic Care Coordination Codes (CCCC)

There were 147 responses to the survey request. The following societies participated in distributing the survey; American Geriatrics Society (AGS), American Academy of Pediatrics (AAP), American College of Cardiologists (ACC), American Academy of Family Physicians (AAFP), American Academy of Neurology (AAN), American Thoracic Society (ATS), American Association of Clinical Endocrinologists (AACE), American College of Rheumatology (ACR), American College of Physicians (ACP), American Osteopathic Association (AOA), American College of Chest Physicians (ACCP), American Association of Nurse Practitioners (AANP), American Nursing Association (ANA), American Gastroenterological Association (AGA), The Endocrine Society (TES) and the American Society of Gastrointestinal Endoscopy (ASGE). These societies represent, physicians including MDs and DOs, physician assistants and nurse practitioners. The summary tables included contain total, as well as, breakout survey results. The survey tools were modified adding emphasis for clarifying time in terms of clinical staff and physician time; the modified survey tool was approved by the research subcommittee.

Background

A multi-specialty and multi-discipline expert panel ("panel") reviewed the surveys and developed the following rationale for the recommended work values for the Transitional Care Management (TCM) and complex chronic care coordination (CCCC) codes.

The TCM and CCCC codes are conceptually new services and have not previously been surveyed. These are services provided to patients with multiple conditions who require coordination of care that is provided by clinical staff under the supervision of a physician, as well as care provided directly by the physician. The care is predominantly non-face-to-face (NFTF) but, in some cases, also includes face-to-face (FTF) care. The panel kept in mind that any FTF visit included in these services was not a traditional E/M service and that the E/M documentations guidelines for history, physical and medical decision making would not apply. As an example, a FTF visit included in a TCM or CCCC service might consist largely of evaluating functional and cognitive status, adverse reactions to medications, medication reconciliation and education rather than performing a traditional history or physical exam.

The panel also kept in mind that the TCM and CCCC codes do not include physician or clinical staff time or work performed for unrelated activities. For example, NFTF and FTF care provided for an acute respiratory infection or abdominal pain that occurs during the month a TCM or CCCC code is reported are not included in the TCM or CCCC code and are reported separately.

There is one major difference between the CCCC and TCM codes - the reporting criteria for the CCCC codes are based on clinical staff time - not physician time. Therefore, the CCCC codes should only be billed for the most complex patients who require a case manager to coordinate care for all the patient's medical problems. Codes 99487 and 99489 do not include any FTF services. If a patient is seen during a calendar month when the code can be reported (i.e., sufficient clinical staff time is spent on NFTF care), then 99488 is reported. Most of the physician work for 99487 and 99489 is spent in supervising clinical staff, although some may be for direct patient care.

Similar to the TCM codes, all physician time in the CCCC codes is considered intraservice time, because it includes all time spent in a calendar month.

The panel also noted that the respondents have never valued codes that involve care coordination and oversight of staff services that are essential components to these types of care. Because of this, and as described in more detail below, the expert panel believes the surveys are flawed in some aspects. First, respondents had to estimate both physician time and staff time for each TCM and CCCC service. Even though many respondents reported that they provide these services, it appeared that they did not properly account for the amount of clinical staff time required for each service and that they did not account for all of the physician time or work involved in NFTF supervision.

Reference Services

For 99487, the key reference services were codes:

- 99374, *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes* with a work RVU of 1.1 and total time of 34 minutes (5/20/9) and
- 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family* with a work RVU of 1.5 and total time of 40 minutes (5/25/10).

The survey median RVU for 99487 was 1.50 with a total time of 45 minutes and with a survey 25th percentile work 1.00 and total time 26 minutes.

For 99489, the key reference services were code 99367 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more* with an RVU of 1.10 and total time of 40 minutes (5/30/5) and code 99214 with a work RVU of 1.50 and total time of 40 minutes (5/25/10). The survey median RVU for 99489 was 1.10 with a total time of 30 minutes.

For 99488, which include a FTF visit, the key reference service was code 99350, *Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family* with an RVU of 3.28 and total time of 110 minutes (15/75/20).

The FTF service chosen as most similar to the FTF service included in 99488 was code 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family* with an RVU of 2.11 and total time of 65 minutes (15/35/15).

The survey median RVU for 99488 was 2.50 with a total time of 60 minutes.

Recommendation and Rationale

The expert panel determined that the first service to value in this family was 99488, so it could be placed in the proper rank order with the TCM codes, both of which also have FTF visits included. Once this was accomplished, then 99487 and 99489 could be valued relative to 99488.

Our expert panel reviewed the data and tried to place 99488 into proper rank order with the two TCM codes just reviewed. However, this was difficult to do because the survey median physician time for 99488 of 60 minutes was only 5 minutes more than the total time of 99215, the E/M selected as most like the face to face portion of 99488 - seemingly leaving little time for non face to face supervision of the clinical staff. Moreover, the total time was identical to the total median survey time for 99496 which had a median RVU of 3.05. In addition, our expert panel believed that the respondents overestimated physician time and work for the two non face to face codes.

After much discussion, we are making the recommendations contained in the attachments. For 99488, we are recommending the survey median physician time and work. The recommended physician time of 60 minutes places it in proper ratio with the total clinical staff time of 107 minutes. Even if the face to face portion of 99488 takes 35 minutes, the same as 99215, that still leaves 25 minutes for non-face to face care over the calendar month.

With respect to the physician work, we believe the service is less intense than 99496 for two reasons: (1) the CCCC codes require moderate OR highly complex medical decision making, whereas 99496 only requires highly complex medical decision making and (2) because the patient's condition is well known to the physician due to ongoing CCCC. In the case of TCM codes, the patient's condition post-discharge is not known to the physician, making the patient similar to a new patient.

In order to maintain proper rank order, for 99487, the survey 25th percentiles for time and physician work - 26 minutes and 1.0 RVUs are a more accurate estimate than the medians and result in the proper ratio of physician to clinical staff time of 26/60. In

order to maintain these ratios, the physician time for 99489 should be 13 minutes - for a ratio of 13/30 and the physician work for 99489 should be 0.5 RVUS which is half the amount for 99487.

The most pertinent comparison services for 99487 are codes:

CPT	Description	wRVU	Total Time (Pre/intra/post)
99374	*Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes*	1.10	34 minutes (5/20/9)
99367	*Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician*	1.10	40 minutes (5/30/5)
GXXXX3	*Medical Home Project Tier 3 (times 3)*	1.05	27.6 minutes (all Intra-time)
93281	*Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system*	0.90	30 minutes (5/20/5)
76813	*Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation*	1.18	35 minutes (5/20/10)

99487 CCCC, first hour CST, no F2F visit

In summary, the expert panel recommends the 25th percentile survey work RVU of 1.00 and 25th service survey time totaling 26 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The CCCC codes are conceptually new services, see attached spreadsheet for details.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Commonly

Specialty Family Practice How often? Commonly

Specialty Geriatrics How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated that less than 10 percent of the 99214 and 99215 visits might qualify to bill the service, second we estimated that even if the service qualified, 50 percent of less might actually receive the service. We then split that total amoung the three codes assuming the 99487 would have slightly more volume than the 99488 code and much less common would a provider qualify to bill the 99489.

Specialty Internal Medicine Frequency 0 Percentage 0.00 %

Specialty Family Practice Frequency 0 Percentage 0.00 %

Specialty Geriatrics Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,003,744 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. For Medicare we assume 1/3 of the total population.

Specialty Internal Medicine Frequency 0 Percentage 0.00 %

Specialty Family Practice Frequency 0 Percentage 0.00 %

Specialty Geriatrics Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99374

Additional Information

Yes or No	Patient comes in for office visit(s)	Patient is admitted to the hospital	Perform work without code to report services	Time is paid for as a medical director	Other (please specify)
Yes or No	If Survey Participant Answered 0 (zero) for any one of the three CCCC codes, they were also asked additional information for clarification.				

Those that answered (0) Zero to performance rate		
	Response	Percentage
Yes	51	37%
No	87	63%
Total	138	100%

Additional Information Services				
Tell us more:	Patient Comes In	Patient Admitted	No Code To Report	Paid as Med Director
Response	33	15	49	8

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99489 Tracking Number F3 Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.50**
Global Period: ZZZ RUC Recommended RVU: **0.50**

CPT Descriptor: Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
(List separately in addition to code for primary procedure)
(Report 99489 in conjunction with 99487, 99488)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:
Typical patient (99489) (Adult)
A 92-year-old man living an assisted living facility with Parkinson's disease, mild dementia, depression and diabetes mellitus continues to lose weight and remains withdrawn. The patient's family resides out of state and an attendant sees the patient for 3 hours daily. The clinical staff has already spent 74 minutes in the month performing care coordination services and now spends additional time.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Complex chronic care coordination services are patient centered management and support services provided by physicians, other qualified health care professionals and clinical staff to an individual who resides at home or in a domiciliary, rest home or assisted living facility. These services typically involve clinical staff implementing a care plan directed by the physician or other qualified health care professional. These services address the coordination of care by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activities of daily living.
Patients who require complex chronic care coordination services may be identified by algorithms that utilize reported conditions and services (eg, predictive modeling risk score or repeat admissions or emergency department use) or by clinician judgment. Typical patients have 1 or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. Patients may have medical and psychiatric behavioral co-morbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and

diabetes) that complicate their care. Social support weaknesses or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are expected. Medical decision making as defined in the Evaluation and Management (E/M) guidelines is not only applied to the face-to-face services, but is determined by the nature of the problems addressed by the reporting individual during the month. A plan of care should be documented and shared with the patient and/or caregiver.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2012		
Presenter(s):	Robert Zorowitz, MD (AGS), Thomas Weida (AAFP), Mary Newman, MD (ACP), Eileen Carlson, RN, JD (ANA), Steven Krug, MD (AAP) and Joel Brill, MD (AGA)..		
Specialty(s):	American Geriatrics Society (AGS), American Academy of Pediatrics (AAP), American College of Cardiologists (ACC), American Academy of Family Physicians (AAFP), American Academy of Neurology (AAN), American Thoracic Society (ATS), American Association of Clinical Endocrinologists (AACE), American College of Rheumatology (ACR), American College of Physicians (ACP), American Osteopathic Association (AOA), American College of Chest Physicians (ACCP), American Academy of Family Physicians (AAFP), American Nursing Association (ANA), American Academy of Physician Assistants (AAPA), American Gastroenterological Association (AGA), The Endocrine Society (TES) and the American Society of Gastrointestinal Endoscopy (ASGE).		
CPT Code:	99489		
Sample Size:	8896	**Resp N:** 147	**Response:** 1.6 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**9.00**	30.00	1500.00
Survey RVW:	0.00	0.75	**1.10**	1.66	55.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	20.00	**30.00**	45.00	400.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	99489	**Recommended Physician Work RVU: 0.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**13.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**

Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99367	XXX	1.10	**RUC Time**

CPT Descriptor Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99213	XXX	0.97	**RUC Time**	99,960,280

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family..

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.48	**RUC Time**	18,383,704

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
11045	ZZZ	0.50	**RUC Time**

CPT Descriptor Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 21.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 99489**	**Key Reference CPT Code:** 99367	**Source of Time RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	13.00	30.00	
Median Immediate Post-service Time	0.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**13.00**	**40.00**	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.65	3.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.87	3.74
Urgency of medical decision making	3.50	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.35	3.32
Physical effort required	2.87	2.84
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.84	3.58
Outcome depends on the skill and judgment of physician	3.94	3.61
Estimated risk of malpractice suit with poor outcome	3.23	3.23

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		

Intra-Service intensity/complexity	3.81	3.65
Post-Service intensity/complexity		

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Complex Chronic Care Coordination Codes (CCCC)

There were 147 responses to the survey request. The following societies participated in distributing the survey; American Geriatrics Society (AGS), American Academy of Pediatrics (AAP), American College of Cardiologists (ACC), American Academy of Family Physicians (AAFP), American Academy of Neurology (AAN), American Thoracic Society (ATS), American Association of Clinical Endocrinologists (AACE), American College of Rheumatology (ACR), American College of Physicians (ACP), American Osteopathic Association (AOA), American College of Chest Physicians (ACCP), American Association of Nurse Practitioners (AANP), American Nursing Association (ANA), American Gastroenterological Association (AGA), The Endocrine Society (TES) and the American Society of Gastrointestinal Endoscopy (ASGE). These societies represent, physicians including MDs and DOs, physician assistants and nurse practitioners. The summary tables included contain total, as well as, breakout survey results. The survey tools were modified adding emphasis for clarifying time in terms of clinical staff and physician time; the modified survey tool was approved by the research subcommittee.

Background

A multi-specialty and multi-discipline expert panel ("panel") reviewed the surveys and developed the following rationale for the recommended work values for the Transitional Care Management (TCM) and complex chronic care coordination (CCCC) codes.

The TCM and CCCC codes are conceptually new services and have not previously been surveyed. These are services provided to patients with multiple conditions who require coordination of care that is provided by clinical staff under the supervision of a physician, as well as care provided directly by the physician. The care is predominantly non-face-to-face (NFTF) but, in some cases, also includes face-to-face (FTF) care. The panel kept in mind that any FTF visit included in these services was not a traditional E/M service and that the E/M documentations guidelines for history, physical and medical decision making would not apply. As an example, a FTF visit included in a TCM or CCCC service might consist largely of evaluating functional and cognitive status, adverse reactions to medications, medication reconciliation and education rather than performing a traditional history or physical exam.

The panel also kept in mind that the TCM and CCCC codes do not include physician or clinical staff time or work performed for unrelated activities. For example, NFTF and FTF care provided for an acute respiratory infection or abdominal pain that occurs during the month a TCM or CCCC code is reported are not included in the TCM or CCCC code and are reported separately.

There is one major difference between the CCCC and TCM codes - the reporting criteria for the CCCC codes are based on clinical staff time - not physician time. Therefore, the CCCC codes should only be billed for the most complex patients who require a case manager to coordinate care for all the patient's medical problems. Codes 99487 and 99489 do not include any FTF services. If a patient is seen during a calendar month when the code can be reported (i.e., sufficient clinical staff time is spent on NFTF care), then 99488 is reported. Most of the physician work for 99487 and 99489 is spent in supervising clinical staff, although some may be for direct patient care.

Similar to the TCM codes, all physician time in the CCCC codes is considered intraservice time, because it includes all time spent in a calendar month.

The panel also noted that the respondents have never valued codes that involve care coordination and oversight of staff services that are essential components to these types of care. Because of this, and as described in more detail below, the expert panel believes the surveys are flawed in some aspects. First, respondents had to estimate both physician time and staff time for each TCM and CCCC service. Even though many respondents reported that they provide these services, it appeared that they did not properly account for the amount of clinical staff time required for each service and that they did not account for all of the physician time or work involved in NFTF supervision.

Reference Services

For 99487, the key reference services were codes:

- 99374, *Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes* with a work RVU of 1.1 and total time of 34 minutes (5/20/9) and
- 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family* with a work RVU of 1.5 and total time of 40 minutes (5/25/10).

The survey median RVU for 99487 was 1.50 with a total time of 45 minutes and with a survey 25th percentile work 1.00 and total time 26 minutes.

For 99489, the key reference services were code 99367 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more* with an RVU of 1.10 and total time of 40 minutes (5/30/5) and code 99214 with a work RVU of 1.50 and total time of 40 minutes (5/25/10). The survey median RVU for 99489 was 1.10 with a total time of 30 minutes.

For 99488, which include a FTF visit, the key reference service was code 99350, *Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family* with an RVU of 3.28 and total time of 110 minutes (15/75/20).

The FTF service chosen as most similar to the FTF service included in 99488 was code 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family* with an RVU of 2.11 and total time of 65 minutes (15/35/15).

Recommendation and Rationale

The expert panel determined that the first service to value in this family was 99488, so it could be placed in the proper rank order with the TCM codes, both of which also have FTF visits included. Once this was accomplished, then 99487 and 99489 could be valued relative to 99488.

Our expert panel reviewed the data and tried to place 99488 into proper rank order with the two TCM codes just reviewed. However, this was difficult to do because the survey median physician time for 99488 of 60 minutes was only 5 minutes more than the total time of 99215, the E/M selected as most like the face to face portion of 99488 - seemingly leaving little time for non-face to face supervision of the clinical staff. Moreover, the total time was identical to the total median survey time for 99496 which had a median RVU of 3.05. In addition, our expert panel believed that the respondents overestimated physician time and work for the two non-faces to face codes.

After much discussion, we are making the recommendations contained in the attachments. For 99488, we are recommending the survey median physician time and work. The recommended physician time of 60 minutes places it in proper ratio with the total clinical staff time of 107 minutes. Even if the face to face portion of 99488 takes 35 minutes, the same as 99215, that still leaves 25 minutes for non-face to face care over the calendar month.

With respect to the physician work, we believe the service is less intense than 99496 for two reasons: (1) the CCCC codes require moderate OR highly complex medical decision making, whereas 99496 only requires highly complex medical decision making and (2) because the patient's condition is well known to the physician due to ongoing CCCC. In the case of TCM codes, the patient's condition post-discharge is not known to the physician, making the patient similar to a new patient.

In order to maintain proper rank order, for 99487, the survey 25th percentiles for time and physician work - 26 minutes and 1.0 RVUs are a more accurate estimate than the medians and result in the proper ratio of physician to clinical staff time of 26/60. In order to maintain these ratios, the physician time for 99489 should be 13 minutes - for a ratio of 13/30 and the physician work for 99489 should be 0.5 RVUS which is half the amount for 99487.

The most pertinent comparison services for 99489 are codes:

CPT	Description	wRVU	Total Time (Pre/intra/post)
99212	*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.*	0.48	16 minutes (2/10/4 minutes)
GXXXX3	*Medical Home Project Tier 3 (times 1.5)*	0.53	13.8 minutes (all intra-time)
11045	*Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)*	0.50	15 minutes (all intra-time)
15276	*Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)*	0.50	10 minutes (all intra-time)

99489 CCCC, each additional 30 minutes (add-on code)

In summary, the expert panel recommends ½ the value and time of 99487 to preserve rank order with a work RVU of 0.50 and 13 minutes total time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) The CCCC codes are conceptually new services, see attached spreadshet for details.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Sometimes

Specialty Family Practice How often? Sometimes

Specialty Geriatrics How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimated that less than 10 percent of the 99214 and 99215 visits might qualify to bill the service, second we estimated that even if the service qualified, 50 percent of less might actually receive the service. We then split that total amoung the three codes assuming the 99487 would have slightly more volume than the 99488 code and much less common would a provider qualify to bill the 99489.

Specialty Internal Medicine Frequency 0 Percentage 0.00 %

Specialty Family Practice Frequency 0 Percentage 0.00 %

Specialty Geriatrics Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 363,909 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. For Medicare we estiamted 1/3 of the total population.

Specialty Internal Medicine Frequency 0 Percentage 0.00 %

Specialty Family Practice Frequency 0 Percentage 0.00 %

Specialty Geriatrics Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 99374

Additional Information

Yes or No	Patient comes in for office visit(s)	Patient is admitted to the hospital	Perform work without code to report services	Time is paid for as a medical director	Other (please specify)
Yes or No	If Survey Participant Answered 0 (zero) for any one of the three CCCC codes, they were also asked additional information for clarification.				

Those that answered (0) Zero to performance rate		
	Response	Percentage
Yes	51	37%
No	87	63%
Total	138	100%

Additional Information Services				
Tell us more:	Patient Comes In	Patient Admitted	No Code To Report	Paid as Med Director
Response	33	15	49	8

ISSUE: Complex Chronic Care Coordination Services

TAB: 9 *10/5/2012 Version*

Source	CPT	Short DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	INTRA OR OWN TIME - MONTH MIN	INTRA OR OWN TIME - MONTH 25th	INTRA OR OWN TIME - MONTH MED	INTRA OR OWN TIME - MONTH 75th	INTRA OR OWN TIME - MONTH MAX	IMMD POST
REF	99214	E/M established pt, 2 of 3 key elements, presenting problem moderate to high severity, Physicians typically spend 25 minutes face-to-face with the patient and/or family.	38	0.047			1.50			40	5			25			10
SVY-T	99487	CCCC Services; first hour of clinical staff time; NO face-to- face visit, per calendar month	147	0.033	0.00	1.00	1.50	2.00	25.00	45		0	26	45	60	600	
	99374	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) within a calendar month; 15-29 minutes		0.039			1.10			34	5			20			9
	99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician		0.029			1.10			40	5			30			5
	GXXXX3	Medical Home Project Tier 3		0.038			0.35			9.2				9.2			
	GXXXX3	Medical Home Project Tier 3		0.038			1.05			27.6				27.6			
	93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system		0.034			0.90			30	5			20.0			5
	76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation		0.042			1.18			35	5			20.0			10
REC F1	99487	CCCC Services; first hour of clinical staff time; NO face-to- face visit, per calendar month		0.038			1.00			26				26			

Source	CPT	Short DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	INTRA OR OWN TIME - MONTH MIN	INTRA OR OWN TIME - MONTH 25th	INTRA OR OWN TIME - MONTH MED	INTRA OR OWN TIME - MONTH 75th	INTRA OR OWN TIME - MONTH MAX	IMMD POST
REF	99350	Physician supervision of a patient under care home health (patient not present) requiring complex and multidisciplinary care modalities, a calendar month; 15-29 minutes	29	0.033			3.28			110	15			75			20
REF F2F Visit	99215	Office or other outpatient visit for the E/M of an established patient, which requires at least 2 of these 3 key components: A comprehensive history;Physicians typically spend 40 minutes face-to-face with the patient and/or family.	41	0.047			2.11			55	5			35			15
SVY- T	99488	CCCC Services; first hour of clinical staff time; ONE face-to-face visit, per calendar month	147	0.042	0.00	1.50	2.50	3.50	30.00	60		0	40	60	90	800	
	74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed		0.050			2.50			57	5			45			7
	95954	Pharmacological or physical activation requiring physician attendance during EEG recording of activation phase (eg, thiopental activation test)		0.037			2.45			70	5			60			5
	99326	Domiciliary or RMV for the E/M of a new patient, Medical decision making of moderate complexity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.		0.043			2.63			77	15			45			17
	90947	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription		0.041			2.52			70	10			50			10
REC F2	99488	CCCC Services; first hour of clinical staff time; ONE face-to-face visit, per calendar month		0.042			2.50			60				60			

Source	CPT	Short DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	INTRA OR OWN TIME - MONTH MIN	INTRA OR OWN TIME - MONTH 25th	INTRA OR OWN TIME - MONTH MED	INTRA OR OWN TIME - MONTH 75th	INTRA OR OWN TIME - MONTH MAX	IMMD POST
REF	99214	E/M established pt, 2 of 3 key elements, presenting problem moderate to high severity, Physicians typically spend 25 minutes face-to-face with the patient and/or family.	28	0.047			1.50			40	5			25			10
REF	99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	31	0.029			1.10			40	5			30			5
SVY- T	99489	CCCC Services; each additional 30 minutes of clinical staff time, per calendar month	147	0.037	0.00	0.75	1.10	1.66	55.00	30		0	20	30	45	400	
	99212	Office outpatient visit for the E/M Straightforward medical decision making.Physicians typically spend 10 minutes face-to-face		0.035			0.48			16	2			10.0			4
	GXXXX3	Medical Home Project Tier 3		0.038			0.53			13.8				13.8			
	11045	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)		0.033			0.50			15				15			
	15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)		0.050			0.50			10				10			
REC F3	99489	CCCC Services; each additional 30 minutes of clinical staff time, per calendar month		0.038			0.50			13				13			

One half of physician time and work of 99487

06 Utilization Spreadsheet 10-6-2012

Tab 9 - CCCC

Utilization Calculation

2011 Medicare Data RUC Database

CPT Code	Estimated % Qualify by CPT criteria	Frequency Projected Total	% Qualify Pool Frequency	Projected Total Utilization for CCCC Family
99214	0.10	81,311,416	8,131,142	
99215	0.10	9,665,755	966,576	**9,097,717**
Total		**90,977,171**	**9,097,717**	

2013 Code	Estimate% Utilization split* between the codes	Distribution between codes	Assumption for yearly is 1/3 of all the procedures are Medicare	Yearly National	Percent Projected Avoidance	Medicare Avoided 99213, 99214 or 99215 Visits	Total Yearly Avoided 99213, 99214 or 99215 Visits
99487	**0.55**	5,003,744	**3**	15,011,233	20%	1,000,749	3,002,247
99488	**0.41**	3,730,064	**3**	11,190,192	100%	3,730,064	11,190,192
99489	**0.04**	363,909	**3**	1,091,726	20%	72,782	218,345
Total	100%	**9,097,717**	**3**	**27,293,151**		**4,803,595**	**14,410,784**

Breakdown not projected of each of the saved visits, assume equal distribution.

Specialty	Percentage breakdown	Yearly Medicare: 99487 CCCC 60 min w/o visit	99488 CCCC 60 min with visit	99489 CCCC each add 30 min
Internal Medicine	**0.40**	2,001,498	1,492,026	145,563
Family Practice	**0.40**	2,001,498	1,492,026	145,563
Geriatrics	**0.20**	1,000,749	746,013	72,782
Total	100%	**5,003,744**	**3,730,064**	**363,909**
			9,097,717	

Note: We expect to see ER and Hospitalization Reduction not accounted for in these projections.

Tab 9 **CPT Code:** 99487, 99488, 99489
Specialty Society('s) AAFP, AAN, ANA, AAP, AACE, ACC, ACCP, ACP, ACRh, AGA, AGS, AOA, ASGE, ATS, TES

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor:
99487 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with **no** face-to-face visit, per calendar month
99488 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with **one** face-to-face visit, per calendar month
99489 Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Global Period: 99487 and 99488: XXX, 99489: ZZZ Meeting Date: October 2012

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

A consensus panel of experts from the surveying societies, including physicians, nurses, and physician assistants, met by phone and email to develop the inputs.

A reference code must be provided for comparison to the practice expense inputs on your spreadsheet. Please provide a rationale for the selection of reference codes. Comparison Code Rationale:
99488: The reference code for the face-to-face visit portion of the visit is 99214.

Please describe in detail the clinical activities of your staff:
99488 only, activities for face-to-face visit:

Pre-Service Clinical Labor Activities:

Review/read X-ray, lab, pathology reports, care plan
Service Clinical Labor Activities:
Activities face-to-face during visit:

- Greet patient/provide gowning
- Obtain vital signs
- Prep and position patient
- Review history, systems, and medications
- Prepare room, equipment, supplies
- Assist physician during exam
- Education/instruction/counseling
- Coordinate home or outpatient care
- Clean room/equipment

Post-Service Clinical Labor Activities:

Activities associated with face-to-face visit:

- Phone calls between visits with patient, family, pharmacy

For 99487, 99488 & 99489, activities NOT associated with the-face-to-face visit:

Pre-Service Clinical Labor Activities:
Service Clinical Labor Activities:
Care coordination activities performed by clinical staff may include:

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care,
- communication with home health agencies and other community services utilized by the patient,
- collection of health outcomes data and registry documentation,
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living,
- assessment and support for treatment regimen adherence and medication management,
- identification of available community and health resources,
- facilitating access to care and services needed by the patient and/or family, development and maintenance of a comprehensive care plan

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE							
2				99214		99487		99488		99489	
3	**Meeting Date: October 2012** **Complex Chronic Care Coordination**	**CMS Code**	**Staff Type**	Office OP visit for the E/M established patient. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes F2F with the patient and/or family.		Complex chronic care coordination services; **first hour of clinical staff time** directed by a physician or other qualified health care professional with no **F2F visit**, **per calendar month**		Complex chronic care coordination services; **first hour of clinical staff time** directed by a physician or other qualified health care professional **with one F2F visit**, **per calendar month**		Complex chronic care coordination services; each additional **30 minutes of clinical staff time** directed by a physician or other qualified health care professional, **per calendar month** (List separately in addition to code for primary procedure)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**ZZZ**	
6	**TOTAL CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**53.0**	**0.0**	**60.0**	**0.0**	**107.0**	**0.0**	**30.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**3.0**	**0.0**	**0.0**	**0.0**	**3.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**44.0**	**0.0**	**60.0**	**0.0**	**104.0**	**0.0**	**30.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L042A**	**RN/LPN**	**6.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
10	**PRE-SERVICE**										
11	**Start: Following visit when decision for surgery or procedure made**										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity - *specify: Review/read X-ray, lab, pathology reports*	L037D	RN/LPN/MTA	**3**				**3**			
18	**End: When patient enters office/facility for surgery/procedure**										
19	**SERVICE PERIOD**										
20	**Start: When patient enters office/facility for surgery/procedure:**										
21	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	**3**				**3**			
22	Obtain vital signs	L037D	RN/LPN/MTA	**5**				**5**			
23	Provide pre-service education/obtain consent										
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	**2**				**2**			
25	Setup scope (non facility setting only)										
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	**2**				**2**			
27	Sedate/apply anesthesia										
28	**Intra-service**										
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	**5**				**5**			
30	**Post-Service**										
31	Monitor pt. following service/check tubes, monitors, drains										
32	Clean room/equipment by physician staff			**3**				**3**			
33	Clean Scope										
34	Clean Surgical Instrument Package										
35	Complete diagnostic forms, lab & X-ray requisitions										
36	Review/read X-ray, lab, and pathology reports										
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	**11**				**11**			
38	Other Clinical Activity - specify: Review/read X-ray, lab, pathology reports	L037D	RN/LPN/MTA	**13**				**13**			
39	Care coordination activities performed by clinical staff may include: communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care; communication with home health agencies and other community services utilized by the patient; collection of health outcomes data and registry documentation; patient and/or family/caretaker education to support self-management, independent living, and activities of daily living; assessment and support for treatment regimen adherence and medication management; identification of available community and health resources; facilitating access to care and services needed by the patient and/or family, development and maintenance of a comprehensive care plan	L042A	RN/LPN			**60**		**60**		**30**	
40	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			**n/a**		**n/a**		**n/a**		**n/a**	
41	Dischrg mgmt (1.0 x 99238) (enter 12 min)			**n/a**		**n/a**		**n/a**		**n/a**	
42	Dischrg mgmt (1.0 x 99239) (enter 15 min)			**n/a**		**n/a**		**n/a**		**n/a**	
43	**End: Patient leaves office**										

	A	B	C	D	E	F	G	H	I	J	K
1				REFERENCE CODE							
2				99214		99487		99488		99489	
3	**Meeting Date: October 2012** **Complex Chronic Care Coordination**	**CMS Code**	**Staff Type**	Office OP visit for the E/M established patient. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes F2F with the patient and/or family.		Complex chronic care coordination services; **first hour of clinical staff time** directed by a physician or other qualified health care professional with no **F2F visit**, **per calendar month**		Complex chronic care coordination services; **first hour of clinical staff time** directed by a physician or other qualified health care professional **with one F2F visit**, **per calendar month**		Complex chronic care coordination services; each additional **30 minutes of clinical staff time** directed by a physician or other qualified health care professional, **per calendar month** (List separately in addition to code for primary procedure)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**XXX**		**XXX**		**XXX**		**ZZZ**	
44	**POST-SERVICE Period**										
45	**Start: Patient leaves office/facility**										
46	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	**6**				**0**			
55	**End: with last office visit before end of global period**										
56	**MEDICAL SUPPLIES**	**CODE**	**UNIT**								
57	pack, minimum multi-specialty visit	SA048	pack								
58	pack, EM visit	SA047	pack	**1**				**1**			
59	**EQUIPMENT**	**CODE**									
60	otoscope-ophthalmoscope (wall unit)	EQ189		**44**				**44**			
61	table, exam	EF023		**44**				**44**			

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS Request – Final Rule for 2021

January 2021

Insertion of Interlaminar/Interspinous Device – Tab 26

22867 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level***
In May 2015, the CPT Editorial Panel converted two Category III codes to Category I and added two Category III codes to describe the insertion of the interlaminar-interspinous process stability device. At the October 2015 RUC meeting, the RUC agreed that the specialty societies should present CPT codes 22840, 22867 and 22868 at the January 2016 RUC meeting concurrently with the new CPT codes for insertion of spinal stability distraction device without decompression. At the January 2016 RUC meeting, CPT codes 22867 and 22868 were reviewed concurrently with the new CPT codes for insertion of spinal stability distraction device without decompression. CMS did not accept the RUC recommendations for CPT codes 22867 and 22869 at that time. In the NPRM for 2021, CMS received public nomination that code 22867 is potentially misvalued.

In their request, the submitters suggested that the physician work assigned to CPT code 22867 significantly undervalues the procedure relative to the value of CPT code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU=15.37, 90 minutes intra-service time and 362 minutes total time). The submitters stated that the work performed during the surgical steps to perform a laminectomy for both procedures is generally similar except for the additional intensity and complexity involved in code 22867 to implant the interspinous stabilization device. After considering the information provided by the submitter, which suggests that the current valuation for the service may not reflect the level of intensity inherent in furnishing the service relative to other similar services with inputs that exceed those for the nominated service, CMS proposed to nominate CPT code 22867 as potentially misvalued and welcomed public comment on this code**.** The RUC reviewed this service at the January 2021 RUC meeting and supports CMS' analysis that the code is misvalued.

In January 2016, the RUC determined an appropriate work value for code 22867 based on a direct crosswalk to CPT code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU=15.00, 90 minutes intra-service time and 270 minutes total time) and noted that both services have similar physician work, identical intra-service time and nearly identical total time. Given these similarities, the RUC recommended a work RVU of 15.00 and further justified this value by comparing 22867 to CPT code 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU=15.00, 90 minutes intra-service time and 270 minutes total time). The RUC recommended a work RVU of 15.00 for CPT code 22867. This RUC recommended value considered and accounted for the higher intraoperative intensity of 22867 when compared with similar code 63047 as noted above. However, in the Final Rule for CY 2017, CMS did not accept the RUC recommended work RVU and instead assigned a work RVU of 13.50 based on a crosswalk to CPT code 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)* (work RVU=13.50, 90 minutes intra-service time and 276 minutes total time).

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

The RUC restates its strong support for the initial crosswalk to CPT code 29915. It notes that utilization for code 22867 has been stable the past three years and that the procedure, patient, and technology has not changed since the 2016 valuation. **Therefore, the RUC agrees with the stakeholder societies and recommends that the work RVU recommendation of 15.00 for CPT code 22867 as presented in 2016 be affirmed.**

Affirm RUC Recommendations
The RUC affirms its January 2016 work RVU recommendation of 15.00 for CPT code 22867.

Practice Expense
The Practice Expense Subcommittee reviewed and affirmed the direct practice inputs from January 2016 without modification. **The RUC recommends the direct practice expense inputs as affirmed by the Practice Expense Subcommittee.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	090	15.00 (Affirmed January 2016 RUC recommendation)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

December 14, 2020

Peter K. Smith, MD
Chair, AMA/Specialty Society RVS Update Committee
AMA Plaza
330 N Wabash Avenue, Suite 39300
Chicago, IL 60611-5885

Dear Dr. Smith,

Code 22867, *Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level,* was identified by CMS as potentially misvalued in the CY 2021 Medicare Physician Fee Schedule proposed rule published in August 2020. The RUC requested review of the code at the January 2021 meeting.

The American Academy of Orthopaedic Surgeons (AAOS), the American Association of Neurosurgeons (AANS), the Congress of Neurological Surgeons (CNS), the North American Spine Society (NASS) and the International Society for Advancement of Spine Surgery (ISASS) have reviewed the history of the code's RUC surveys and valuation and support CMS' analysis that the code is misvalued.

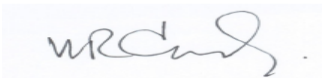
At the January 2016 RUC meeting, the RUC reviewed the survey results from two separate surveys of code 22867 by 85 and by 58 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed that the specialties' recommendation of the survey 25th percentile physician work value of 16.47 (the lower of the two sets of survey data) overvalued the work involved in performing this service. To determine an appropriate work value for 22867, the RUC reviewed code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU=15.00, intra-service time of 90 minutes, total time of 270 minutes) and noted that both services have similar physician work, identical intra-service time and nearly identical total time. Given these similarities, the RUC recommended a work RVU of 15.00, which is a direct crosswalk to code 29915. To further justify this value, the RUC also compared 22867 to code 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU=15.00, intra-service time of 90 minutes, total time of 270 minutes) and noted that both services have similar physician work, identical intra-service time and nearly identical total times. However, in the final rule for CY 2017, CMS did not accept the RUC recommended work RVU and instead assigned a work RVU of 13.50 based on a crosswalk to code 36832 *Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)*.

We note that (1) a majority of the RUC survey respondents indicated procedure experience in the 12 months prior to the RUC survey, (2) utilization has been stable the past three years, and (3) the procedure, patient, and technology has not changed. This code was surveyed twice and had the exact same time and visit results. The expense and time for a third survey of this low

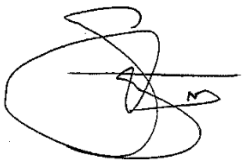
volume code is not justified. Therefore, the stakeholder societies recommend that the RUC reaffirm the survey time and visit data presented in 2016 and re-affirm the RUC 2016 work RVU recommendation of 15.00 for code 22867. This RUC recommended value considered and accounted for the higher intraoperative intensity of 22867 when compared with similar code 63047, *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar*.

Thank you for your consideration of this request.

Sincerely,



William R. Creevy, MD
AAOS RUC Advisor



Karin Swartz, MD
NASS RUC Advisor



John Ratliff, MD
AANS RUC Advisor



Clemens Schirmer, MD
CNS RUC Advisor



Morgan Lorio, MD
ISASS RUC Advisor

ISSUE: Insertion of Spinal Stability Distraction Device

TAB: 26

								RVW					Total	pre	PRE			INTRA					POST-FACILITY				OFFICng		
SOURCE	CPT	GLOB	DESC	Resp	IWPUT	WPUT	MIN	25th	MED	75th	MAX	Time	PKG	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	PKG	32	31	38	14	13	12	57
REF1	63047	090	Laminectomy, facetectomy and forar		0.077	0.042			15.37			362		40	15	20			90			30		1	1	1	3			
REF2	63005	090	Laminectomy with exploration and/or		0.046	0.037			16.43			450		85					143			35		1	2	1	3			
current	22867	090	Insertion of interlaminar/interspinous		0.090	0.050			13.50			271	3	33	15	15			90			30	9b			1	3			
RUC 2017	22867	090	Insertion of interlaminar/interspinous proces		0.106	0.055			15.00			271	3	33	15	15	20	56	90	90	180	30	9b			1	3			
REC	22867	090	REAFFIRMATION OF 2016 RUC RECOMMENDATION TIME AND WORK RVU		0.106	0.055			15.00			271	3	33	15	15			90			30	9b			0.5	3			

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2016

Insertion of Spinal Stability Distractive Device

At the May 2015 CPT meeting, the CPT Editorial Panel converted two Category III codes to Category I and added two Category III codes to describe the insertion of the interlaminar/interspinous process stability device. The specialty societies noted that, during their survey process, they learned that a CPT code change proposal to create Category I codes for insertion of spinal stability distraction device without decompression was submitted for consideration for the October 2015 CPT Editorial Panel meeting. The societies noted the codes in this new CPT proposal are closely related to those that were surveyed for the October 2015 RUC meeting , and therefore, requested for postponing consideration of CPT codes 22840, 22867 and 22868 until the January 2016 RUC meeting so both code sets could be reviewed simultaneously. The RUC agreed that the specialty societies should present CPT codes 22840, 22867 and 22868 at the January 2016 RUC meeting concurrently with the new CPT codes for insertion of spinal stability distraction device without decompression. At the October 2015 CPT meeting, the CPT Editorial Panel converted two Category III codes to Category I codes to report insertion of spinous distraction device(s) without concurrent performance of open decompression.

22840 ***Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)***
The specialty societies noted and the RUC agreed that CPT code 22840 is not part of the same code family as the new spinal stability distraction device codes. CPT code 22840 is part of a different family of rigid fixation codes intended to be used for spinal fusion and with additional fusion codes. This service is commonly performed with minimal open exposure, often on an outpatient basis, and has little in common with the technique of transarticular screw fixation, which is an open procedure performed on an inpatient basis.

22867 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level***
The RUC reviewed the survey results from 58 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: pre-service time of 63 minutes (pre-time package of 3 with 12 minutes added to the standard package for positioning), intra-service time of 90 minutes and immediate post-service time of 30 minutes (post-service package 9B with 3 minutes removed from the standard package). The median survey immediate post-operative time was 20 minutes, though the CMS' 23-hour stay rule was also applied to this outpatient service. To apply CMS' rule, the intra-service time was reallocated from the same-day Evaluation and Management (E/M) code 99231 to the immediate post-service time (adding 10 minutes from the intra-service time). A majority of respondents (87%) indicated that the typical patient will stay overnight or be admitted. Of the survey respondents that indicated the patient was kept overnight, the majority indicated that the

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

typical patient will require an E/M visit later the same day. The RUC agreed with the specialty that a ½ day discharge visit (99238) is appropriate for this procedure that is typically performed in a facility. The RUC also concurred with the specialty that three 99213 office visits during the 090-day global period are typical.

The RUC reviewed the survey 25th percentile physician work value and agreed that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 22867, the RUC reviewed CPT code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU=15.00, intra-service time of 90 minutes, total time of 270 minutes) and noted that both services have similar physician work, identical intra-service time and nearly identical total time. Given these similarities, the RUC recommends a work RVU of 15.00, which is a direct crosswalk to CPT code 29915. To justify this value, the RUC compared 22867 to CPT code 29916 *Arthroscopy, hip, surgical; with labral repair* (work RVU=15.00, intra-service time of 90 minutes, total time of 270 minutes) and noted that both services have similar physician work, identical intra-service time and nearly identical total times. **The RUC recommends a work RVU of 15.00 for CPT code 22867.**

22868 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: intra-service time of 45 minutes.

The RUC reviewed the surveyed 25th percentile work RVU of 4.00 and agreed with the specialties that this value appropriately accounts for the physician work involved. To justify a work RVU of 4.00, the RUC compared the survey code to MPC code 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU=4.88, intra-service time of 45 minutes) and noted that both services have identical intra-service time and total time, supporting the proposed work RVU for the survey code. The RUC also reviewed CPT code 37237 *Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)* (work RVU= 4.25, intra-service time of 45 minutes, total time of 47 minutes) and noted that both services have similar physician work, identical intra-service times and similar total times. **The RUC recommends a work RVU of 4.00 for CPT code 22868.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

22869 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level***
The RUC reviewed the survey results from 58 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: pre-service time of 63 minutes (pre-time package of 3 with 12 minutes added to the standard package for positioning), intra-service time of 43 minutes and immediate post-service time of 30 minutes (post-service package 9B with 3 minutes removed from the standard package). The median survey immediate post-operative time was 20 minutes, though the CMS' 23-hour stay rule was also applied to this outpatient service. To apply CMS' rule, the intra-service time was reallocated from the same-day E/M code 99231 to the immediate post-service time (adding 10 minutes from the intra-service time). A majority of respondents (71%) indicated that the typical patient will stay overnight or be admitted. Of the survey respondents that indicated the patient was kept overnight, the majority indicated that the typical patient will require an E/M visit later the same day. The RUC agreed with the specialty that a ½ day discharge visit (99238) is appropriate for this procedure that is typically performed in a facility. The RUC also concurred with the specialty that one 99213 office visit and one 99212 office visit during the 090-day global period are typical.

The RUC reviewed the survey 25th percentile physician work value and agreed that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 22869, the RUC reviewed CPT code 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed* (work RVU= 7.39, intra-service time of 45 minutes, total time of 199 minutes) and noted that both services have similar physician work, near identical intra-service times, though the survey code has more total time. Given these similarities, the RUC recommends a work RVU of 7.39, which is a direct crosswalk to CPT code 29880. To justify this value, the RUC compared 22869 to CPT code 22511 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral* (work RVU= 7.58, intra-service time of 45 minutes, total time of 160 minutes) and noted that both services have similar physician work, near identical intra-service times, though the survey code has more total time. **The RUC recommends a work RVU of 7.39 for CPT code 22869.**

22870 ***Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 49 orthopaedic surgeons, neurosurgeons and spine surgeons and agreed on the following physician time components: intra-service time of 30 minutes.

The RUC reviewed the survey 25th percentile physician work value and agreed that the survey respondents overvalued the work involved in performing this service. To determine an appropriate work value for 22870, the RUC reviewed CPT code 22103 *Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)* (work RVU= 2.34, intra-service time of 30 minutes) and noted that both services have

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

similar physician work, identical intra-service and total times. Given these similarities, the RUC recommends a work RVU of 2.34, which is a direct crosswalk to CPT code 22103. To justify this value, the RUC compared 22870 to MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU= 2.25, intra-service time of 30 minutes) and note that both services have identical intra-service times and total times, whereas the survey code involves somewhat more intensity. **The RUC recommends a work RVU of 2.34 for CPT code 22870.**

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

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

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Musculoskeletal System **Spine (Vertebral Column)**				
22100		*Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical*		
22101		*thoracic*		
22102		*lumbar*		
		(For insertion of posterior spinous process distraction devices, see ~~0171T, 0172T~~ 22867, 22868, 22869, 22870*)*		
22851		*Application of intervertebral biomechanical device(s) (eg,synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)*		
		(Use 22851 in conjunction with 22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327,		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

	22532, 22533, 22548-22558, 22590-22612, 22630,22633, 22634, 22800-22812, 63001-63030, 63040-63042,63045-63047, 63050-63056, 63064, 63075, 63077, 63081,63085, 63087, 63090, 63101, 63102, 63170-63290,63300-63307) *(For application of an intervertebral bone device/graft,see 20930-20938)* *(For insertion of posterior spinous process distraction devices, see ~~0171T, 0172T~~ 22867, 22868,* 22869, 22870*)*			
✚22840(f)	A1	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure) (Use 22840 in conjunction with 22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307) (For insertion of posterior spinous process distraction devices, see ~~0171T, 0172T~~ 22867, 22868, 22869, 22870)	ZZZ	Specialty Society – Code Not Part of the Family
D0171T		~~Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumber; single level~~		
D✚0172T		~~each additional level (List separately in addition to code for primary procedure)~~ (0171T has been deleted. To report insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level, see ~~2286~~22867. To report		

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

		insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level see 22869) (0172T has been deleted. To report insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level, see ~~22868~~22868. To report insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level see 22870)		
●22867	A2	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	090	15.00
✚●22868	A3	second level (List separately in addition to code for primary procedure) *(Report 22868 in conjunction with 22867)* *(Do not report 22867, 22868 in conjunction with 22532, 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22840, 22841, 22842, 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63048, 77003, 22869, 22870 for the same level)* *(For insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, use 22869)*	ZZZ	4.00
●22869	A4	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	090	7.39

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

✚●22870	A5	second level (List separately in addition to code for primary procedure) *(Report 22870 in conjunction with 22869)* *(Do not report 22869, 22870 in conjunction with 22532, 22533, 22534, 22558, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22840, 22841, 22842, 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63048, 77003)*	ZZZ	2.34

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22867 Tracking Number A2 Original Specialty Recommended RVU: **16.47**
Presented Recommended RVU: **16.47**
Global Period: 090 RUC Recommended RVU: **15.00**

CPT Descriptor: Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old woman presents with a 6-month history of progressive low back pain and leg pain unresponsive to conservative treatments including physical therapy, oral medications and an epidural steroid injection. MRI demonstrates severe spinal stenosis at the L4-5 level. Patient is scheduled for an L4-5 lumbar decompression and implantation of an interlaminar/interspinous process stabilization/distraction device.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 95% , In the ASC 5%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 13% , Overnight stay-less than 24 hours 51% , Overnight stay-more than 24 hours 36%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 54%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Perform a targeted H&P. Write orders for preoperative medications and performance standards. Review the surgical procedure, postoperative recovery in and out of the hospital, and expected outcome(s) with the patient and family. Sign and mark the operative site. Obtain informed consent. Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite. Review imaging, and select and display appropriate pictures. Review the length and type of anesthesia with the anesthesiologist. Monitor initial patient positioning for induction of anesthesia. Following induction of anesthesia, assist with repositioning of patient prone with the lumbar spine in flexion. Verify and/or assist with padding of patient to prevent pressure on neurovascular structures. Supervise prepping/draping of the patient. Scrub and gown. Perform a time out to confirm patient and procedure with the OR staff.

Description of Intra-Service Work: Intraoperative imaging is used to identify the correct level and plan the surgical incision. A posterior lumbar incision is made through the skin, subcutaneous tissue, and lumbosacral fascia. Markers are placed and intraoperative imaging is utilized to again confirm the correct level of surgery. A complete decompression of the spinal stenosis removing any obstructing soft or bony tissue is performed. The lamina and spinous processes of the involved segment are fashioned and prepared to allow for the neutral stabilization of the affected vertebral levels. A measuring device is used to determine the size of the interlaminar stabilization device. The implant is selected and the size is verified. The implant is inserted and fixed into place. Final imaging (AP and lateral fluoroscopy) is obtained to confirm proper implant position. Copious irrigation is used and the wound is closed in layers.

Description of Post-Service Work:

Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.

Later same day and on each day patient is in the facility, monitor and document patient progress. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, imaging, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Next day or several days later. Write orders for follow-up, post-discharge labs, imaging, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (ie, diet, activity, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Office: Write orders for medications and follow-up films. Review post-discharge films. Examine patient, performing periodic neurological exams. Monitor wounds and remove sutures. Review use and proper fit of brace with patient. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for the medical chart. Answer questions (oral and written) from patient, family and insurance staff. Discuss patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2016		
Presenter(s):	John Ratlilff, MD; Alexander Mason, MD; Henry Woo, MD; Charles Mick, MD; Karin Swartz, MD; Morgan Lorio, MD; William Creevy, MD; John Heiner, MD		
Specialty(s):	AANS/CNS, NASS, ISASS, AAOS		
CPT Code:	22867		
Sample Size:	1403	**Resp N:** 58	**Response:** 4.1 %
Description of Sample:	AAOS: A random selection from membership database. Targeted samples within society membership approved by Research Subcommittee: AANS/CNS. A random selection from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves. NASS. A random selection of only "surgeon" members of NASS (ie, there are also non-surgeon members). ISASS: A random selection of only U.S. surgeon members of ISASS (ie, this is an international society that includes non U.S. members).		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	8.00	60.00
Survey RVW:	10.00	16.47	**18.00**	21.88	28.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	56.00	**90.00**	90.00	180.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	22867	**Recommended Physician Work RVU: 15.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**69.00**	99211x **0.00** 12x **0.00** 13x **3.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63047	090	15.37	**RUC Time**

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63005	090	16.43	**RUC Time**

CPT Descriptor Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
60500	090	15.60	**RUC Time**	14,522

CPT Descriptor 1 Parathyroidectomy or exploration of parathyroid(s);

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37215	090	18.00	**RUC Time**	6,589

CPT Descriptor 2 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 17 **% of respondents:** 29.3 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 22.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 22867	**Top Key Reference CPT Code:** 63047	**2nd Key Reference CPT Code:** **63005**
Median Pre-Service Time	63.00	75.00	85.00
Median Intra-Service Time	90.00	90.00	143.00
Median Immediate Post-service Time	30.00	30.00	35.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	60.00	80.00
Median Discharge Day Management Time	19.0	38.00	38.00
Median Office Visit Time	69.0	69.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**271.00**	**362.00**	**450.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	Top Key Ref Code	**2nd Key Ref Code**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	0.71	0.38
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.53	0.23
Urgency of medical decision making	0.24	0.00

Technical Skill/Physical Effort (Mean)

Technical skill required	0.82	0.54
Physical effort required	0.65	0.31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	0.65	0.15
Outcome depends on the skill and judgment of physician	0.53	0.46
Estimated risk of malpractice suit with poor outcome	0.47	0.31

INTENSITY/COMPLEXITY MEASURES	Top Key Ref Code	2nd Key Ref Code
Time Segment (Mean)		
Overall intensity/complexity	0.94	0.62

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

At the June 2006 CPT Panel meeting, the Panel approved two Category III codes to report insertion of posterior lumbar spinous process distraction devices.

0171T Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level

0172T each additional level (List separately in addition to code for primary procedure)

At the May 2015 CPT Panel meeting, two new Category I codes (22867 and 22868) were approved for reporting the insertion of an interlaminar stabilization device to stabilize the spine following open decompression for the treatment of lumbar spinal stenosis at one or two levels. At this same meeting, the Panel established two Category III codes to report interlaminar stabilization insertion without open decompression.

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 second level (List separately in addition to code for primary procedure)

043XT Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

043XT second level (List separately in addition to code for primary procedure)

During the process of conducting a RUC survey of the two new codes in July 2015, the AANS/CNS, NASS, and AAOS were informed that a coding change proposal was submitted by individual practitioners to convert the new Category III

codes for interlaminar stabilization insertion **without** open decompression to Category I status. The RUC Advisors from AANS/CNS, NASS, and AAOS petitioned the RUC to delay presentation of the survey data collected for 22867 and 22868 until after the October 2015 CPT meeting so that data for all four codes could be presented together. The RUC approved this request, but with the caveat that 22867 and 22868 would have to be resurveyed (ie, the RUC wanted all four codes surveyed together).

At the October 2015 CPT Panel meeting, the Category III codes were converted to Category I codes (22869 and 22870). These two new codes describe interlaminar stabilization insertion **without** open decompression in contrast to the two codes (22867 and 22868) approved previously that describe interlaminar stabilization insertion **with** open decompression. None of the four codes include fusion.

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 second level (List separately in addition to code for primary procedure)

22869 Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

22870 second level (List separately in addition to code for primary procedure)

Discuss of Survey Process and Respondent Experience

All four codes were included on one survey instrument. For codes 22867 and 22869, the question for site of service and E/M on the same day that is standard in the 10 and 90 day global survey was added. The survey request was sent to a random selection from the AAOS membership database. In addition, targeted samples within the AANS/CNS, NASS, and ISASS membership databases were approved by Research Subcommittee: A random selection from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves. A random selection of only "surgeon" members of NASS (ie, there are also non-surgeon members). A random selection of only U.S. surgeon members of ISASS (ie, this is an international society that includes non U.S. members).

For the first two codes 22867 and 22868, the selection of respondents was random as described above and without consideration of any possible overlap from the previous survey. In addition, for this current survey, a new society (ISASS) also surveyed its members. Therefore, the survey data from the two separate surveys of codes 22867 and 22868 were not combined. However, on the RUC Summary Excel file, we show the summary data from the previous survey of codes 22867 and 22868 in the rows above the current survey data. In addition, we note that we are using the current survey data from the survey of all four codes on one instrument for our recommendations. We also note that three of the four codes have a median experience of zero. This issue will be discussed individually for each code where it applies.

Recommendation – 22867

We recommend the survey 25th percentile work RVU of 16.47 for code 22867.

Pre-Time Package 4

Evaluation: No change in package time of 40 minutes.
Positioning: Add 12 minutes (total = 15 minutes) to position the patient prone with the lumbar spine in flexion.
Scrub, dress, wait: Subtract 5 minutes (total = 15 minutes) to be consistent with the median survey time.

Immediate Postoperative Time and Post-time Package 9b

The median survey immediate post-operative time was 20 minutes. A majority of respondents (87%) indicated that the typical patient will stay overnight or be admitted. The respondents also indicated that the typical patient will require a E/M visit later the same day. Because CMS does not allow reporting inpatient E/M codes for procedures that will have a facility status of outpatient, we have added 10 minutes (total = 30 minutes) to the survey immediate post-time to reflect time for a visit later on the same day. We note that 30 minutes is less than the time for the recommended post-time package.

Key Reference Comparison

Code 22867 is more intense and complex than key reference code 63047, especially with respect to the technical skill required.

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total	PRE	INTRA	POST	33	38	13	12
60500	Parathyroidectomy or exploration of parathyroid(s);	**15.60**	0.086	313	72	**120**	40		0.5	2	1
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	**16.47**	0.121	278	70	**90**	30		0.5	3	
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection	**18.00**	0.121	322	63	**90**	30	1	1	2	

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0171T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate

Specialty neurosurgery Frequency 250 Percentage 50.00 %

Specialty orthopaedic surgery Frequency 250 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 22610

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22868 Tracking Number A3 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: ZZZ RUC Recommended RVU: **4.00**

CPT Descriptor: Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old woman presents with a 6-month history of progressive low back pain and leg pain unresponsive to conservative treatments including physical therapy, oral medications and an epidural steroid injection. MRI demonstrates severe spinal stenosis at the L3-4 and L4-5 levels. Patient is scheduled for an L3-4 and L4-5 lumbar decompression and implantation of interlaminar/interspinous process stabilization/distraction devices. The L4-5 level has just been completed and now the L3-4 level is addressed.
[Note: CPT code 228XB is an add-on service. Only consider the additional physician work related to the second level.]

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: After insertion of the initial lumbar interlaminar/interspinous process stabilization/distraction device with decompression (reported separately), the incision is extended to expose the adjacent level. A complete decompression of the spinal stenosis removing any obstructing soft or bony tissue is performed at this second level. The lamina and spinous processes of the involved segment are fashioned and prepared to allow for the neutral stabilization of the affected vertebral levels. A measuring device is used to determine the size of the interlaminar stabilization device. The implant is selected and the size is verified. The implant is inserted and fixed into place. Final imaging (AP and lateral fluoroscopy) is obtained to confirm proper implant position. Copious irrigation is used and the wound is closed in layers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2016		
Presenter(s):	John Ratlilff, MD; Alexander Mason, MD; Henry Woo, MD; Charles Mick, MD; Karin Swartz, MD; Morgan Lorio, MD; William Creevy, MD; John Heiner, MD		
Specialty(s):	AANS/CNS, NASS, ISASS, AAOS		
CPT Code:	22868		
Sample Size:	1403	**Resp N:** 49	**Response:** 3.4 %
Description of Sample:	AAOS: A random selection from membership database. Targeted samples within society membership approved by Research Subcommittee: AANS/CNS. A random selection from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves. NASS. A random selection of only "surgeon" members of NASS (ie, there are also non-surgeon members). ISASS: A random selection of only U.S. surgeon members of ISASS (ie, this is an international society that includes non U.S. members).		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	3.00	30.00
Survey RVW:	2.34	4.00	**5.50**	8.00	15.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	180.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	22868	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63048	ZZZ	3.47	**RUC Time**

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22534	ZZZ	5.99	**RUC Time**

CPT Descriptor Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
57267	ZZZ	4.88	**RUC Time**	7,891

CPT Descriptor 1 Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
37237	ZZZ	4.25	**RUC Time**

CPT Descriptor Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 24 **% of respondents:** 48.9 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 12.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 22868	Top Key Reference CPT Code: 63048	2nd Key Reference CPT Code: 22534
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	45.00	45.00	60.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**45.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	Top Key Ref Code	2nd Key Ref Code
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	0.54	0.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.46	0.17

Urgency of medical decision making	0.17	0.00

Technical Skill/Physical Effort (Mean)

Technical skill required	0.75	0.00
Physical effort required	0.58	0.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	0.54	0.50
Outcome depends on the skill and judgment of physician	0.58	0.33
Estimated risk of malpractice suit with poor outcome	0.38	0.33

INTENSITY/COMPLEXITY MEASURES	Top Key Ref Code	2nd Key Ref Code
Time Segment (Mean)		
Overall intensity/complexity	0.75	0.17

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

At the June 2006 CPT Panel meeting, the Panel approved two Category III codes to report insertion of posterior lumbar spinous process distraction devices.

0171T Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level

0172T each additional level (List separately in addition to code for primary procedure)

At the May 2015 CPT Panel meeting, two new Category I codes (22867 and 22868) were approved for reporting the insertion of an interlaminar stabilization device to stabilize the spine following open decompression for the treatment of lumbar spinal stenosis at one or two levels. At this same meeting, the Panel established two Category III codes to report interlaminar stabilization insertion without open decompression.

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 second level (List separately in addition to code for primary procedure)

043XT Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

043XT second level (List separately in addition to code for primary procedure)

During the process of conducting a RUC survey of the two new codes in July 2015, the AANS/CNS, NASS, and AAOS were informed that a coding change proposal was submitted by individual practitioners to convert the new Category III codes for interlaminar stabilization insertion **without** open decompression to Category I status. The RUC Advisors from AANS/CNS, NASS, and AAOS petitioned the RUC to delay presentation of the survey data collected for 22867 and 22868 until after the October 2015 CPT meeting so that data for all four codes could be presented together. The RUC approved this request, but with the caveat that 22867 and 22868 would have to be resurveyed (ie, the RUC wanted all four codes surveyed together).

At the October 2015 CPT Panel meeting, the Category III codes were converted to Category I codes (22869 and 22870). These two new codes describe interlaminar stabilization insertion **without** open decompression in contrast to the two codes (22867 and 22868) approved previously that describe interlaminar stabilization insertion **with** open decompression. None of the four codes include fusion.

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 second level (List separately in addition to code for primary procedure)

22869 Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

22870 second level (List separately in addition to code for primary procedure)

Discuss of Survey Process and Respondent Experience

All four codes were included on one survey instrument. For codes 22867 and 22869, the question for site of service and E/M on the same day that is standard in the 10 and 90 day global survey was added. The survey request was sent to a random selection from the AAOS membership database. In addition, targeted samples within the AANS/CNS, NASS, and ISASS membership databases were approved by Research Subcommittee: A random selection from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves. A random selection of only "surgeon" members of NASS (ie, there are also non-surgeon members). A random selection of only U.S. surgeon members of ISASS (ie, this is an international society that includes non U.S. members).

For the first two codes 22867 and 22868, the selection of respondents was random as described above and without consideration of any possible overlap from the previous survey. In addition, for this current survey, a new society (ISASS) also surveyed its members. Therefore, the survey data from the two separate surveys of codes 22867 and 22868 were not combined. However, on the RUC Summary Excel file, we show the summary data from the previous survey of codes 22867 and 22868 in the rows above the current survey data. In addition, we note that we are using the current survey data from the survey of all four codes on one instrument for our recommendations. We also note that three of the four codes have a median experience of zero. This issue will be discussed individually for each code where it applies.

Recommendation – 22868

Although the first survey (07/15) for code 22868 had a median experience of 2, the second survey (10/15) resulted in a median experience of zero.

Time. Our expert panel agree that the current survey median additional intraoperative time of 45 minutes correctly reflects the time required for this this add-on service. We also note that 45 minutes is the same median time in the 07/15 survey data and the same median time for those respondents with experience in the current survey. **We therefore recommend a median intraoperative time of 45 minutes.**

Work RVU. The median and 25th percentile work RVU for the current survey is less than the statistics from the 07/15 survey which had more respondents with experience. We also note that the work RVU statistics in the current survey from respondents with experience are higher than the same data points from those without experience. Our expert panel agrees that the complexity and intensity of 22868 is greater than 63048 and the work RVU should be higher. **We therefore recommend the (current) survey 25th percentile work RVU of 4.00 for code 22868.**

We also recommend that this code be tagged in the RUC database as "Do not use to validate physician work" until such time that a RUC survey is conducted that results in a majority of respondents that have experience in the past 12 months.

Key Reference Comparison

Code 22868 is more intense and complex than key reference code 63048, especially with respect to the technical skill required.

MPC and Other Code Comparison

There are very few ZZZ MPC codes and only one that corresponds to intraoperative time (57267). However, there are other recently reviewed ZZZ codes with similar intensity/complexity that support the recommended work RVU.

CPT	Descriptor	RVW	IWPUT	Total	PRE	INTRA	POST
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	**4.00**	0.089	45	0	**45**	0
57267 MPC	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)	**4.88**	0.108	45	0	**45**	0
37233 (2010)	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	**4.25**	0.093	47	1	**45**	1
37237 (2013)	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)	**4.25**	0.093	47	1	**45**	1
61651 (2015)	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)	**4.25**	0.094	45	0	**45**	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. reported with 228XX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0172T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 150
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate

Specialty neurosurgery Frequency 75 Percentage 50.00 %

Specialty orthopaedic surgery Frequency 75 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 22328

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22869 Tracking Number A4 Original Specialty Recommended RVU: **7.58**
Presented Recommended RVU: **7.39**
Global Period: 090 RUC Recommended RVU: **7.39**

CPT Descriptor: Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A skeletally mature adult with progressive low back pain and leg pain due to a history of neurogenic claudication is unresponsive to conservative treatments. The patient achieves some relief from symptoms in flexion. Imaging confirms mild-moderate spinal stenosis at the L4-5 level, with approximately 50% reduction in spinal canal area. The implantation of a posterior interspinous process distraction device at one level without an open decompression or a fusion is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 88% , In the ASC 12%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 29% , Overnight stay-less than 24 hours 47% , Overnight stay-more than 24 hours 24%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 53%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: Perform a targeted H&P. Write orders for preoperative medications and performance standards. Review the surgical procedure, postoperative recovery in and out of the hospital, and expected outcome(s) with the patient and family. Sign and mark the operative site. Obtain informed consent. Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite Review imaging, and select and display appropriate pictures. Review the length and type of anesthesia with the anesthesiologist. Monitor initial patient positioning for induction of anesthesia. Following induction of anesthesia, assist with repositioning of patient prone with the lumbar spine in flexion. Verify and/or assist with padding of patient to prevent pressure on neurovascular structures and placement of chin straps and arm traction devices to facilitate intraoperative imaging. Supervise prepping/draping of the patient. Scrub and gown. Perform a time out to confirm patient and procedure with the OR staff.

Description of Intra-Service Work: Intraoperative imaging is used to identify the correct level and plan the surgical incision. A posterior lumbar incision is made through the skin, subcutaneous tissue, and lumbosacral fascia. A dilator is inserted through the incision and advanced between the spinous processes and into the interspinous process space under fluoroscopic guidance to confirm levels, position and depth. Additional larger dilators are inserted until the space is distracted to the correct degree. A gauge is used to determine the distance between the two spinous processes, and determine the appropriate implant size. The implant is selected and size verified. The implant is inserted and fixed into place. Final imaging (AP and lateral fluoroscopy) is obtained to confirm proper implant position. Copious irrigation is used and the wound is closed in layers.

Description of Post-Service Work:
Hospital: Apply sterile dressings. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note in chart. Write postoperative note in the recovery room. Dictate operative report and copy referring physician(s). Write orders for transferring to surgical floor and discuss ongoing care with floor nurses.

Later same day and on each day patient is in the facility, monitor and document patient progress. Assess pain scores and adequacy of analgesia. Review nursing/other staff patient chart notes. Write orders for labs, imaging, medications, diet, and patient activity. Chart patient progress notes. Answer patient and family questions. Answer nursing/other staff questions.

Next day or several days later. Write orders for follow-up, post-discharge labs, imaging, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions (ie, diet, activity, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Postoperative Work - In Office: Write orders for medications and follow-up films. Review post-discharge films. Examine patient, performing periodic neurological exams. Monitor wounds and remove sutures. Review use and proper fit of brace with patient. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for the medical chart. Answer questions (oral and written) from patient, family and insurance staff. Discuss patient progress with referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2016		
Presenter(s):	John Ratlilff, MD; Alexander Mason, MD; Henry Woo, MD; Charles Mick, MD; Karin Swartz, MD; Morgan Lorio, MD; William Creevy, MD; John Heiner, MD		
Specialty(s):	AANS/CNS, NASS, ISASS, AAOS		
CPT Code:	22869		
Sample Size:	1403	**Resp N:** 58	**Response:** 4.1 %
Description of Sample:	AAOS: A random selection from membership database. Targeted samples within society membership approved by Research Subcommittee: AANS/CNS. A random selection from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves. NASS. A random selection of only "surgeon" members of NASS (ie, there are also non-surgeon members). ISASS: A random selection of only U.S. surgeon members of ISASS (ie, this is an international society that includes non U.S. members).		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	2.00	30.00
Survey RVW:	8.00	11.87	**12.88**	15.58	23.53
Pre-Service Evaluation Time:			**53.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	15.00	30.00	**43.00**	60.00	240.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**20.00**	99231x **1.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	22869	**Recommended Physician Work RVU: 7.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**33.00**	**33.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**43.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**30.00**	**33.00**	**-3.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22102	090	11.08	**RUC Time**

CPT Descriptor Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63047	090	15.37	**RUC Time**

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
33240	090	6.05	**RUC Time**	870

CPT Descriptor 1 Insertion of implantable defibrillator pulse generator only; with existing single lead

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67904	090	7.97	**RUC Time**	50,117

CPT Descriptor 2 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

Other Reference CPT Code	Global	Work RVU	Time Source
22511	010	7.58	**RUC Time**

CPT Descriptor Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral

---

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 44.8 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 24.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 22869	Top Key Reference CPT Code: 22102	2nd Key Reference CPT Code: **63047**
Median Pre-Service Time	63.00	75.00	75.00
Median Intra-Service Time	43.00	90.00	90.00
Median Immediate Post-service Time	30.00	32.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	60.00	60.00
Median Discharge Day Management Time	19.0	38.00	38.00
Median Office Visit Time	39.0	92.00	69.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**194.00**	**387.00**	**362.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	Top Key Ref Code	2nd Key Ref Code
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	0.08	0.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.19	0.14
Urgency of medical decision making	-0.08	-0.07

Technical Skill/Physical Effort (Mean)

Technical skill required	0.35	0.14
Physical effort required	0.27	0.07

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	0.12	0.00
Outcome depends on the skill and judgment of physician	0.46	0.29
Estimated risk of malpractice suit with poor outcome	0.35	0.21

INTENSITY/COMPLEXITY MEASURES	Top Key Ref Code	2nd Key Ref Code
Time Segment (Mean)		
Overall intensity/complexity	0.27	0.29

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

At the June 2006 CPT Panel meeting, the Panel approved two Category III codes to report insertion of posterior lumbar spinous process distraction devices.

0171T Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level

0172T each additional level (List separately in addition to code for primary procedure)

At the May 2015 CPT Panel meeting, two new Category I codes (22867 and 22868) were approved for reporting the insertion of an interlaminar stabilization device to stabilize the spine following open decompression for the treatment of lumbar spinal stenosis at one or two levels. At this same meeting, the Panel established two Category III codes to report interlaminar stabilization insertion without open decompression.

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 second level (List separately in addition to code for primary procedure)

043XT Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

043XT second level (List separately in addition to code for primary procedure)

During the process of conducting a RUC survey of the two new codes in July 2015, the AANS/CNS, NASS, and AAOS were informed that a coding change proposal was submitted by individual practitioners to convert the new Category III

codes for interlaminar stabilization insertion **without** open decompression to Category I status. The RUC Advisors from AANS/CNS, NASS, and AAOS petitioned the RUC to delay presentation of the survey data collected for 22867 and 22868 until after the October 2015 CPT meeting so that data for all four codes could be presented together. The RUC approved this request, but with the caveat that 22867 and 22868 would have to be resurveyed (ie, the RUC wanted all four codes surveyed together).

At the October 2015 CPT Panel meeting, the Category III codes were converted to Category I codes (22869 and 22870). These two new codes describe interlaminar stabilization insertion **without** open decompression in contrast to the two codes (22867 and 22868) approved previously that describe interlaminar stabilization insertion **with** open decompression. None of the four codes include fusion.

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 second level (List separately in addition to code for primary procedure)

22869 Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

22870 second level (List separately in addition to code for primary procedure)

Discuss of Survey Process and Respondent Experience

All four codes were included on one survey instrument. For codes 22867 and 22869, the question for site of service and E/M on the same day that is standard in the 10 and 90 day global survey was added. The survey request was sent to a random selection from the AAOS membership database. In addition, targeted samples within the AANS/CNS, NASS, and ISASS membership databases were approved by Research Subcommittee: A random selection from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves. A random selection of only "surgeon" members of NASS (ie, there are also non-surgeon members). A random selection of only U.S. surgeon members of ISASS (ie, this is an international society that includes non U.S. members).

For the first two codes 22867 and 22868, the selection of respondents was random as described above and without consideration of any possible overlap from the previous survey. In addition, for this current survey, a new society (ISASS) also surveyed its members. Therefore, the survey data from the two separate surveys of codes 22867 and 22868 were not combined. However, on the RUC Summary Excel file, we show the summary data from the previous survey of codes 22867 and 22868 in the rows above the current survey data. In addition, we note that we are using the current survey data from the survey of all four codes on one instrument for our recommendations. We also note that three of the four codes have a median experience of zero. This issue will be discussed individually for each code where it applies.

Recommendation – 22869

The survey for 22869 resulted in a median experience of zero.

Time. Our expert panel agree that code 22869 will take considerably less intra-operative time than 22867 and that the survey median time of 43 minutes is reasonable. This is based on a review literature including the results of a randomized controlled FDA-IDE pivotal trial. **We therefore recommend a median intraoperative time of 43 minutes.**

Work RVU. With respect to the work RVU, we are not confident that the survey respondents accurately estimated the physician work and believe the median and 25th percentile work RVUs overstate the physician work. Our expert panel agrees that it is important to assign a work RVU for 22869 to establish correct relativity with 22867. We have determined that code 22511, *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral* has similar total physician work when considering intensity, complexity, and time. **We therefore recommend that the work RVU for 22511 of 7.58 be crosswalked to code 22869.**

We also recommend that this code be tagged in the RUC database as "Do not use to validate physician work" until such time that a RUC survey is conducted that results in a majority of respondents that have experience in the past 12 months.

Crosswalk Comparison

CPT	Descriptor	RVW	IWPUT	Total	PRE	INTRA	POST	38	13	12
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	**7.58**	0.084	194	63	**43**	30	0.5	1	1
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	**7.58**	0.98	160	53	**45**	20	0.5	1	

Pre-Time Package 4

Evaluation: No change in package time of 40 minutes.
Positioning: Add 12 minutes (total = 15 minutes) to position the patient prone with the lumbar spine in flexion.
Scrub, dress, wait: Subtract 5 minutes (total = 15 minutes) to be consistent with the median survey time.

Immediate Postoperative Time and Post-time Package 9b

The median survey immediate post-operative time was 20 minutes. A majority of respondents (71%) indicated that the typical patient will stay overnight or be admitted. The respondents also indicated that the typical patient will require a E/M visit later the same day. Although most respondents did not indicate recent experience with this procedure, our expert panel's review of the literature indicates these survey data are correct. Because CMS does not allow reporting inpatient E/M codes for procedures that will have a facility status of outpatient, we have added 10 minutes (total = 30 minutes) to the survey immediate post-time to reflect time for a visit later on the same day. We note that 30 minutes is less than the time for the recommended post-time package.

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total	PRE	INTRA	POST	38	13	12
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	**6.05**	0.077	140	33	**45**	20	0.5	1	
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	**7.58**	0.084	194	63	**43**	30	0.5	1	1
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	**7.97**	0.089	185	35	**45**	15	0.5	1	3

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0171T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate

Specialty neurosurgery Frequency 50 Percentage 50.00 %

Specialty orthopaedic surgery Frequency 50 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 22852

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:22870 Tracking Number A5 Original Specialty Recommended RVU: **2.34**
Presented Recommended RVU: **2.34**
Global Period: ZZZ RUC Recommended RVU: **2.34**

CPT Descriptor: Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A skeletally mature adult with progressive low back pain and leg pain due to a history of neurogenic claudication is unresponsive to conservative treatments. The patient achieves some relief from symptoms in flexion. Imaging confirms mild-moderate spinal stenosis at the L3-L4 with 25% reduction in canal area and at L4-5 with a 50% reduction. The implantation of a posterior interspinous process distraction device without an open decompression or a fusion at both levels is recommended.
[Note: CPT code 228XD is an add-on service. Only consider the additional physician work related to the second level.]

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: n/a

Description of Intra-Service Work: After insertion of the initial lumbar interlaminar/interspinous process stabilization/distraction device with decompression (reported separately), the incision is extended to expose the adjacent level. A dilator is inserted through the incision and advanced between the spinous processes and into the interspinous process space under fluoroscopic guidance to confirm position and depth. Additional larger dilators are inserted until the space is distracted to the correct degree. A gauge is used to determine the distance between the two spinous processes, and determine the appropriate implant size. The implant is selected and size verified. The implant is inserted and fixed into place. Final imaging (AP and lateral fluoroscopy) is obtained to confirm proper implant position. Copious irrigation is used and the wound is closed in layers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2016		
Presenter(s):	John Ratlilff, MD; Alexander Mason, MD; Henry Woo, MD; Charles Mick, MD; Karin Swartz, MD; Morgan Lorio, MD; William Creevy, MD; John Heiner, MD		
Specialty(s):	AANS/CNS, NASS, ISASS, AAOS		
CPT Code:	22870		
Sample Size:	1403	**Resp N:** 49	**Response:** 3.4 %
Description of Sample:	AAOS: A random selection from membership database. Targeted samples within society membership approved by Research Subcommittee: AANS/CNS. A random selection from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves. NASS. A random selection of only "surgeon" members of NASS (ie, there are also non-surgeon members). ISASS: A random selection of only U.S. surgeon members of ISASS (ie, this is an international society that includes non U.S. members).		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	1.00	30.00
Survey RVW:	2.00	2.50	**3.00**	5.00	12.56
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	20.00	**30.00**	30.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	22870	**Recommended Physician Work RVU: 2.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
22103	ZZZ	2.34	**RUC Time**

CPT Descriptor Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
63048	ZZZ	3.47	**RUC Time**

CPT Descriptor Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99292	ZZZ	2.25	**RUC Time**	467,217

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
22103	ZZZ	2.34	**RUC Time**

CPT Descriptor Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 28 **% of respondents:** 57.1 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 18.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 22870	Top Key Reference CPT Code: 22103	2nd Key Reference CPT Code: **63048**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	30.00	30.00	45.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**30.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	Top Key Ref Code	2nd Key Ref Code
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	0.14	0.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.14	0.00
Urgency of medical decision making	-0.04	0.11

Technical Skill/Physical Effort (Mean)

Technical skill required	0.21	0.22
Physical effort required	0.32	0.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	0.18	0.11
Outcome depends on the skill and judgment of physician	0.43	0.33
Estimated risk of malpractice suit with poor outcome	0.18	0.33

INTENSITY/COMPLEXITY MEASURES	Top Key Ref Code	2nd Key Ref Code
Time Segment (Mean)		
Overall intensity/complexity	0.36	0.33

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

At the June 2006 CPT Panel meeting, the Panel approved two Category III codes to report insertion of posterior lumbar spinous process distraction devices.

0171T Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level

0172T each additional level (List separately in addition to code for primary procedure)

At the May 2015 CPT Panel meeting, two new Category I codes (22867 and 22868) were approved for reporting the insertion of an interlaminar stabilization device to stabilize the spine following open decompression for the treatment of lumbar spinal stenosis at one or two levels. At this same meeting, the Panel established two Category III codes to report interlaminar stabilization insertion without open decompression.

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 second level (List separately in addition to code for primary procedure)

043XT Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

043XT second level (List separately in addition to code for primary procedure)

During the process of conducting a RUC survey of the two new codes in July 2015, the AANS/CNS, NASS, and AAOS were informed that a coding change proposal was submitted by individual practitioners to convert the new Category III

codes for interlaminar stabilization insertion **without** open decompression to Category I status. The RUC Advisors from AANS/CNS, NASS, and AAOS petitioned the RUC to delay presentation of the survey data collected for 22867 and 22868 until after the October 2015 CPT meeting so that data for all four codes could be presented together. The RUC approved this request, but with the caveat that 22867 and 22868 would have to be resurveyed (ie, the RUC wanted all four codes surveyed together).

At the October 2015 CPT Panel meeting, the Category III codes were converted to Category I codes (22869 and 22870). These two new codes describe interlaminar stabilization insertion **without** open decompression in contrast to the two codes (22867 and 22868) approved previously that describe interlaminar stabilization insertion **with** open decompression. None of the four codes include fusion.

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 second level (List separately in addition to code for primary procedure)

22869 Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

22870 second level (List separately in addition to code for primary procedure)

Discuss of Survey Process and Respondent Experience

All four codes were included on one survey instrument. For codes 22867 and 22869, the question for site of service and E/M on the same day that is standard in the 10 and 90 day global survey was added. The survey request was sent to a random selection from the AAOS membership database. In addition, targeted samples within the AANS/CNS, NASS, and ISASS membership databases were approved by Research Subcommittee: A random selection from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves. A random selection of only "surgeon" members of NASS (ie, there are also non-surgeon members). A random selection of only U.S. surgeon members of ISASS (ie, this is an international society that includes non U.S. members).

For the first two codes 22867 and 22868, the selection of respondents was random as described above and without consideration of any possible overlap from the previous survey. In addition, for this current survey, a new society (ISASS) also surveyed its members. Therefore, the survey data from the two separate surveys of codes 22867 and 22868 were not combined. However, on the RUC Summary Excel file, we show the summary data from the previous survey of codes 22867 and 22868 in the rows above the current survey data. In addition, we note that we are using the current survey data from the survey of all four codes on one instrument for our recommendations. We also note that three of the four codes have a median experience of zero. This issue will be discussed individually for each code where it applies.

Recommendation – 22870

The survey for 22870 resulted in a median experience of zero.

Time. Our expert panel agrees that code 22870 will take considerably less intra-operative time than 22868 and that the survey median time of 30 minutes is reasonable. **We therefore recommend a median intraoperative time of 30 minutes.**

Work RVU. With respect to the work RVU, we are not confident that the survey respondents accurately estimated the physician work and believe the median and 25th percentile work RVUs overstate the physician work. Our expert panel agrees that it is important to assign a work RVU for 22870 to establish correct relativity with 22868. We have determined that key reference code 22103, *Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)* has the same total physician work when considering intensity, complexity, and time. **We therefore recommend that the work RVU for 22103 of 2.34 be crosswalked to code 22870.**

We also recommend that this code be tagged in the RUC database as "Do not use to validate physician work" until such time that a RUC survey is conducted that results in a majority of respondents that have experience in the past 12 months.

MPC and Other Code Comparison

There are very few ZZZ MPC codes and only one that corresponds to intraoperative time (99292). However, there are other recently reviewed ZZZ codes with similar intensity/complexity that support the recommended work RVU.

CPT	Descriptor	RVW	IWPUT	Total	PRE	INTRA	POST
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	**2.34**	0.078	30	0	**30**	0
99292 MPC	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)	**2.25**	0.075	30	0	**30**	0
43273 (2013)	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	**2.24**	0.075	30	0	**30**	0
49327 (2010)	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code(s) for primary procedure)	**2.38**	0.079	30	0	**30**	0
36476 (2014)	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	**2.65**	0.088	30	0	**30**	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Report with 228X4

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0172T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty neurosurgery How often? Rarely

Specialty orthopaedic surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. specialty estimate

Specialty neurosurgery Frequency 10 Percentage 50.00 %

Specialty orthopaedic surgery Frequency 10 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 22116

ISSUE: Insertion of Spinal Stability Distraction Device

TAB: 5

SOURCE	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	pre PKG	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	POST-FACILITY P-SD	POST-FACILITY PKG	OFFIC 32	OFFIC 31	OFFIC 38	OFFIC 14	OFFIC 13	OFFIC 12	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
REF1	63047	Laminectomy, facetectomy and foran	17	0.077			15.37			362		40	15	20			90			30		1	1	1	3							
REF2	63005	Laminectomy with exploration and/or	13	0.046			16.43			450		85					143			35		1	2	1	3							
current	0171T	Insertion of posterior spinous proces		NA						0																						
SVY-07/15	22867	Insertion of interlaminar/interspinous	85	0.140	11.00	17.00	20.00	22.06	55.27	337		60	15	15	45	70	90	120	180	30		1	1	3	0	0	3	10	75			
SVY-11/15	22867	Insertion of interlaminar/interspinous	58	0.120	10.00	16.47	18.00	21.88	28.00	327		60	15	15	20	56	90	90	180	20		1	1	3	0	0	2	8	60			
REC	22867	Crosswalk to work RVU for 29915		0.106			15.00			271	3	33	15	15			90			30	9b		0.5	3								
REF1	63048	Laminectomy, facetectomy and foran	24	0.077			3.47			45		0					45			0												
REF2	22534	Arthrodesis, lateral extracavitary tech	6	0.100			5.99			60		0					60			0												
current	0172T	Insertion of posterior spinous proces		NA						0																						
SVY-07/15	22868	Insertion of interlaminar/interspinous	73	0.140	2.50	4.50	6.00	8.16	16.00	45		0			10	30	45	60	240	0								0	0	2	4	50
SVY-11/15	22868	second level (List separately in addit	49	0.122	2.34	4.00	5.50	8.00	15.00	45		0	0	0	10	30	45	60	180	0								0	0	0	3	30
REC	22868	Survey 25th percentile		0.089			4.00			45	ZZZ	0					45			0	ZZZ											
		WITH experience	24	0.133	2.34	4.45	6.00	8.88	12.56	45		0			20	30	45	60	120	0								1	2	3	13	30
		WITHOUT experience	25	0.143	2.34	3.75	5.00	6.75	15.00	35		0			10	30	35	60	180	0								0	0	0	0	0
REF1	22102	Partial excision of posterior vertebral	26	0.014			11.08			387		75					90			32		3	1.0	4								
REF2	63047	Laminectomy, facetectomy and foran	14	0.077			15.37			362		40	15	20			90			30		1	1	1.0	3							
current	0171T	Insertion of posterior spinous proces		NA						0																						
SVY-11/15	22869	Insertion of interlaminar/interspinous	58	0.172	8.00	11.87	12.88	15.58	23.53	242		53	15	15	15	30	43	60	240	20		1	1.0	1	1		0	0	0	2	30	
REC	22869	Crosswalk to work RVU for 29880		0.080			7.39			194	3	33	15	15			43			30	9b		0.5	1	1							
		WITH experience	21	0.246	11.08	12.00	15.00	16.50	23.53	259		60	20	20	15	30	35	60	240	20		1	1.0	1	1		1	2	4	5	30	
		WITHOUT experience	37	0.139	8.00	11.08	12.25	15.00	22.00	249		50	15	15	15	30	45	60	120	20		1	1.0	1	1		0	0	0	0	0	
REF1	22103	Partial excision of posterior vertebral	28	0.078			2.34			30		0					30			0												
REF2	63048	Laminectomy, facetectomy and foran	9	0.077			3.47			45		0					45			0												
current	0172T	Insertion of posterior spinous proces		NA						0																						
SVY-11/15	22870	Insertion of interlaminar/interspinous	49	0.100	2.00	2.50	3.00	5.00	12.56	30		0	0	0	10	20	30	30	120	0								0	0	0	1	30
REC	22870	Crosswalk to work RVU for 22103		0.078			2.34			30	ZZZ	0					30			0	ZZZ											
		WITH experience	15		2.34	2.42	3.47	6.88	12.56	30		0			15	25	30	38	90	0								1	1	3	5	30
		WITHOUT experience	34		2.00	2.50	3.00	4.23	10.00	30		0			10	16	30	30	120	0								0	0	0	0	0

Tab Number: 5

Issue: Insertion of Spinal Stability Distraction Device

Code(s): 22840, 228XX, 228X0, 228X4 & 228X5

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

Signature:	
Print Name:	John Ratliff, MD
Specialty Society:	American Association of Neurological Surgeons
Date:	December 13, 2015

Tab Number: 5

Issue: Insertion of Spinal Stability Distraction Device

Code(s): 22840, 228XX, 228X0, 228X4 & 228X5

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

Signature:	
Print Name:	William Creevy, MD
Specialty Society:	American Academy of Orthopaedic Surgery
Date:	December 13, 2015

Tab Number: 5

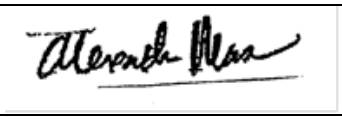
Issue: Insertion of Spinal Stability Distraction Device

Code(s): 22840, 228XX, 228X0, 228X4 & 228X5

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

Signature:	
Print Name:	Alexander Mason, MD
Specialty Society:	Congress of Neurological Surgeons
Date:	December 13, 2015

Tab Number: 5

Issue: Insertion of Spinal Stability Distraction Device

Code(s): 22840, 228XX, 228X0, 228X4 & 228X5

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

Signature:	
Print Name:	Morgan P. Lorio, MD
Specialty Society:	International Society for the Advancement of Spine Surgery
Date:	December 13, 2015

Tab Number: 5

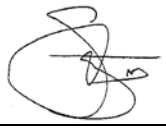
Issue: Insertion of Spinal Stability Distraction Device

Code(s): 22840, 228XX, 228X0, 228X4 & 228X5

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

Signature:	
Print Name:	Karin Swartz, MD
Specialty Society:	North American Spine Society
Date:	December 13, 2015

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	090
22868	second level (List separately in addition to code for primary procedure)	ZZZ
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	090
22870	second level (List separately in addition to code for primary procedure)	ZZZ

Meeting Date: January 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The Advisors from the participating specialties reviewed the standards for 90-day global and ZZZ global procedures.

2. You must provide reference code(s) for comparison on your spreadsheet. Current inputs for 63047 and 63048 are used as reference. These were key reference codes.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
22867 and 22869 (090): The typical patients requiring these services will have a long standing history of low back pain. These procedures will be performed on an elective basis and all aspects of pre-service clinical staff work that is typical of 90-day global procedures will apply to codes 22867 and 22869: complete pre-service diagnostic & referral forms, coordinate pre-surgery services, schedule space and equipment in facility, provide pre-service education/obtain consent, and follow-up phone calls & prescriptions.
22868 and 22870 (ZZZ): N/A. These are add-on codes.

Service Clinical Labor Activities:
22867 and 22869 (090): Clinical staff will assist the surgeon with discharge management, including arrangements for post-discharge imaging, home care, and responding to patient and family questions.
22868 and 22870 (ZZZ): N/A. These are add-on codes.

Post-Service Clinical Labor Activities:
22867 and 22869 (090): Clinical staff will assist the surgeon at post-op office visits.
22868 and 22870 (ZZZ): N/A. These are add-on codes.

CPT Code: 22867,22868,22869,22870
Specialty Society: AANS, CNS, NASS, ISASS, AAOS

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

NO INPUTS FOR NON-FACILITY SETTING

CPT Long Descriptor:

22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	090
22868	second level (List separately in addition to code for primary procedure)	ZZZ
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	090
22870	second level (List separately in addition to code for primary procedure)	ZZZ

Meeting Date: January 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The Advisors from the participating specialties reviewed the standards for 90-day global and ZZZ global procedures.

2. You must provide reference code(s) for comparison on your spreadsheet. N/A

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Revised to add exam light per PE Subcommittee Review - 01/13/16			REF CODE		Recommend		Recommend		REF CODE		Recommend		Recommend	
2				63047		22867		22869		63048		22868		22870	
3	**Meeting Date: 01/2016** **Tab: 5** **Specialty: AANS, CNS, NASS, ISASS, AAOS**	**CMS Code**	**Staff Type**	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of		Insertion of interlaminar/interspinous process stabilization/distraction device, without		Insertion of interlaminar/interspinous process stabilization/distraction device, without open		Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of		second level (List separately in addition to code for primary procedure)		second level (List separately in addition to code for primary procedure)	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**N/A**	**180**	**N/A**	**174**	**N/A**	**129**	**N/A**	**0**	**N/A**	**0**	**N/A**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA		**60**		**60**		**60**		**0**		**0**		**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA		**12**		**6**		**6**		**0**		**0**		**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA		**108**		**108**		**63**		**0**		**0**		**0**
10	**PRE-SERVICE**														
11	**Start: Following visit when decision for surgery or procedure made**														
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA		**5**		**5**		**5**						
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA		**20**		**20**		**20**						
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA		**8**		**8**		**8**						
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA		**20**		**20**		**20**						
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA		**7**		**7**		**7**						
18	**End: When patient enters office/facility for surgery/procedure**														
19	**SERVICE PERIOD**														
20	**Start: When patient enters office/facility for surgery/procedure:**														
42	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)						**6**		**6**						
43	Dischrg mgmt (1.0 x 99238) (enter 12 min)	**L037D**	RN/LPN/MTA		**12**										
45	**End: Patient leaves office**														
46	**POST-SERVICE Period**														
47	**Start: Patient leaves office/facility**														
49	***Office visits: List Number and Level of Office Visits***			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
50	99211 16 minutes		16												
51	99212 27 minutes		27						**1**						
52	99213 36 minutes		36		**3**		**3**		**1**						
53	99214 53 minutes		53												
54	99215 63 minutes		63												
55	**Total Office Visit Time**	**L037D**	RN/LPN/MTA		**108**		**108**		**63**		**0**		**0**		**0**
57	**End: with last office visit before end of global period**														
58	**MEDICAL SUPPLIES***	**CODE**	**UNIT**												
59	pack, minimum multi-specialty visit	SA048	pack		**3**		**3**		**2**						
60	pack, post-op incision care (suture)	SA054	pack				**1**		**1**						
61	pack, post-op incision care (staple)	SA052	pack		**1**										
62	**EQUIPMENT**	**CODE**													
63	table, power	EF031			**108**		**108**		**63**						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Site of Service Anomaly*

January 2021

Knee Arthroplasty – Tab 27

In October 2020, the Relativity Assessment Workgroup identified CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* with Medicare data from 2017-2019e that was performed less than 50% of the time in the inpatient setting yet included inpatient hospital Evaluation and Management services within the global period and 2019e Medicare utilization over 10,000. The Workgroup reviewed hospital outpatient claims data to confirm that this service is typically performed in the outpatient setting without any observation or overnight stay. Of 414 carrier line items (from the 5% physician claim files) for CPT code 27446 that were matched to a hospital outpatient claim, just 44 (11 percent) appear to have involved observation care with an overnight stay. The Workgroup noted that CPT code 27446 is a site of service anomaly and visits are currently included in this service that are not typical of what is occurring. The RUC recommended that CPT code 27446 be surveyed for January 2021 with the appropriate code family.

At the January 2021 meeting, the specialty societies submitted a request to defer survey until April 2021 due to logistical reasons including timing and a desire to be placed on the Research Subcommittee agenda "to review a proposed revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work." It is the RUC's understanding that the specialty societies will survey the code family and develop recommendations for presentation at the April 2021 RUC meeting. The RUC notes that the family of services should be identified on the level of interest (LOI). **The RUC recommends that CPT code 27446 be surveyed for April 2021 with the appropriate code family.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	090	Request to Survey April 2021 RUC Meeting

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

American Academy of Orthopaedic Surgeons
American Association of Hip and Knee Surgeons
9400 West Higgins Road
Rosemont, IL 60018-4976

December 14, 2020

Peter K. Smith, MD
Chair, AMA Relative Value Update Committee
AMA Plaza
330 N Wabash Avenue, Suite 3930
Chicago, IL 60611-5885

Dear Dr. Smith,

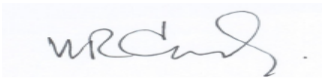
The RUC placed CPT code 27446, Arthroplasty, knee, condyle and plateau; medial OR lateral compartment on the CMS/RAW Level of Interest form for the January 2021 RUC meeting (Tab 27). 27446 was flagged by the RAW in the October 2020 RUC cycle for a site-of-service anomaly with more than 50% of current Medicare utilization outpatient . The RAW report to the full RUC automatically elevated the code to survey, without an action plan, for the January 2021 meeting.

The AAOS and AAHKS have responded to the LOI and indicated we will develop recommendations for the RUC for the code. At this time, our societies recommend survey for presentation at the April 2021 RUC meeting.

We also request at this time that CPT code 27446 be placed on the Research Committee agenda to review a proposed revised survey instrument to ask about additional pre-operative time and resources spent on pre-optimization patient work.

Thank you for your time and attention and please let us know if you have any questions.

Sincerely,



William R. Creevy, MD
AAOS RUC Advisor



Adolph Yates, MD
AAHKS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

AstraZeneca and Janssen SARS-CoV-2-Immunization Administration

On November 5, 2020, the CPT Editorial Panel created four codes to describe immunization administration (IA) by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. CPT codes 0001A and 0002A are used to report the first and second dose administration of the Pfizer-BioNTech COVID-19 vaccine (ie 30 mcg/0.3mL dosage, diluent reconstituted). CPT codes 0011A and 0012A are used to report the first and second dose administration of the Moderna COVID-19 vaccine (ie 100 mcg/0.5mL dosage.

On December 14, 2020, the CPT Editorial Panel created two codes to describe immunization administration (IA) by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. Codes 0021A and 0022A are used to report the first and second dose administration of the AstraZeneca vaccine. Subsequently on January 14, 2021, the CPT Editorial Panel created one new code to describe immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine. Code 0031A is used to report the administration of the Janssen vaccine.

These CPT codes, developed based on extensive collaboration with CMS and the Centers for Disease Control and Prevention (CDC), are unique for each of the four coronavirus vaccines as well as administration codes unique to each corresponding vaccine and dose. The new CPT codes clinically distinguish each COVID-19 vaccine for better tracking, reporting and analysis that supports data-driven planning and allocation. In addition, CPT Appendix Q was created to facilitate an easy guide for proper reporting of all SARS-CoV-2 vaccine CPT codes.

In January 2021, the RUC reviewed the two AstraZeneca SARS-CoV-2 immunization administration codes and in February 2021, the RUC reviewed the Janssen SARS-CoV-2 immunization administration code. The specialty societies provided background on the previous valuation of CPT code 90470 *H1N1 immunization administration (intramuscular, intranasal), including counseling when performed.*

Background on Immunization Administration Valuation

During the October 2009 meeting, the RUC provided recommendations for CPT code 90640 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* (work RVU = 0.20; 7 minutes intra-service time) and direct practice expense (PE) inputs. During the same meeting, the RUC reviewed recommendations for CPT code 90470 which was fast-tracked to address the immediate need to vaccinate against the 2009 H1N1 pandemic.

In 2009, at the request of the Department of Health and Human Services, the CPT Editorial Panel created new CPT code 90470 to assist the public health effort to immediately vaccinate for H1N1. CMS requested that the RUC immediately review the new service and provide recommendations on the estimated physician work and direct practice expense inputs necessary to provide the immunization. The RUC recommended the same work

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

RVU of 0.20 and 7 minutes of intra-service time for H1N1 code 90470 as it did for CPT code 90460. Additionally, the RUC recommended the direct PE inputs for CPT code 90470 be equivalent to CPT code 90460 with two primary exceptions. First, an additional two minutes of staff time were added to capture the additional work of identifying and contacting patients as the vaccine is provided by the state. In addition, the standard greet patient time of 3 minutes was added since an evaluation and management code is not additionally reported as part of the typical patient encounter for vaccinating during a pandemic.

CMS accepted the RUC recommendations for CPT code 90470, publishing a work RVU 0.20 and PE RVU of 0.42 on the 2010 Medicare Physician Payment Schedule (MFS), representing the resources utilized in vaccinating the public during a pandemic. CPT code 90470 was sunset at the end of the H1N1 pandemic.

CMS crosswalked CPT code 90460 to CPT code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid*) (work RVU = 0.17) which, in turn, was hard coded to CPT code 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* (work RVU = 0.17).

In the Proposed Rule for 2021, CMS noted that the IA payment rates resulting from the CPT code 96372 hard coding were substantially lower than the CDC regional maximum charges. CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services, as it is critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. The RUC will review all non-COVID related immunization codes at the April 2021 RUC meeting.

AstraZeneca and Janssen SARS-CoV-2 (COVID-19) Immunization Administration

The RUC reviewed the specialty society recommendations and agreed that 0021A, 0022A and 0031A should be crosswalked to the 2009 RUC recommendation for CPT code 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* (2009 recommended work RVU = 0.20 and 7 minutes of intra-service time). This is also the same work RVU established for 90470 during the H1N1 pandemic.

For additional support the RUC referenced codes 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.20 and 7 minutes total time), 99188 *Application of topical fluoride varnish by a physician or other qualified health care professional* (work RVU = 0.20 and 9 minutes total time) and 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 9 minutes total time).

In the case of some COVID-19 vaccine requiring two doses, the total physician work resources required for the first dose should be equivalent to those required for the second dose to account for the possibility that a patient may not return to the same physician or even the same physician group for the second dose administration. Valuation must account for any necessary physician work to confirm the details of a patient's first dose. The specialty societies indicated, and the RUC agreed, that the first and second dose both require 7 minutes of physician time. Data from the Phase III clinical trials indicate that patients receiving the second dose are more likely to experience adverse effects and the physician involvement

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

addressing such questions are the same for both doses. The RUC agreed that there is no difference in physician work between the administration of the first and second dose, nor is there any difference in physician work or time to administer the Pfizer-BioNTech, Moderna or AstraZeneca immunizations. The RUC recommends the AstraZeneca and Janssen COVID-19 IA codes be crosswalked to the 2009 RUC recommendations for CPT code 90460 with respect to work and intra-service time. **The RUC recommends a work RVU of 0.20 and intra-service time of 7 minutes for CPT codes 0021A,0022A and 0031A.**

Practice Expense

The Practice Expense (PE) Subcommittee thoroughly and extensively discussed the practice expense inputs involved with the SARS-CoV-2 immunization administration codes in the physician office setting in its December 2020 review of the Pfizer and Modera IA codes and determined the same direct inputs apply to the AstraZeneca and Janssen IA codes. The Subcommittee compared the direct PE inputs for the new IA codes with reference code 90460 and former CPT code 90470 and determined that the clinical staff times approved for code 90470 during the 2009 pandemic were appropriate. The inputs mirror the clinical staff times that had been in place for CPT code 90470. The Subcommittee also determined that new CPT code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease* would be utilized with these codes and confirmed that there is no overlap in clinical staff times, with what is already included in CPT code 99072. **The RUC strongly recommends that CMS approve payment for CPT code 99072 during the PHE.**

The specialty societies emphasized that though the clinical staff activities may be similar to other vaccination codes, the typical amount of clinical staff time is higher due to the requirements inherent in a public health emergency and due to these services not being typically reported with an evaluation and management service during a PHE. There was significant discussion regarding the considerable documentation requirements that accompany these immunization administration codes. There was agreement that 2 minutes was appropriate for the first dose of both vaccines to identify and contact appropriate patients and schedule immunization. The recommendation for CA033 *Perform regulatory mandated quality assurance activity (service period)* was maintained the same as was recommended for the Pfizer and Moderna IA codes, as L026A *Medical/Technical Assistant* is appropriate for this type of registry. A lesser amount of clinical staff time was allotted for CA034 *Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)* with L037D *RN/LPN/MTA,* recognizing that more than baseline medical knowledge is required for this activity. There was also recognition that the initial data entry would require more time and the minutes for CA033 and CA034 in the subsequent codes were reduced accordingly. The CDC recommends 15 minutes of monitoring the patient following the administration of each dose for both vaccines. The PE Subcommittee agreed that the standard of 1 minute of clinical staff time to every 4 minutes of patient monitoring is appropriate, leading to 4 minutes of clinical staff monitoring time. A follow-up phone call from the patient to the practice to discuss symptoms or address questions was accepted as typical.

The PE Subcommittee extensively discussed the supply and equipment inputs associated with the initial Pfizer and Moderna immunization administration codes. The same supplies are recommended for the AstraZeneca and Janssen IA codes with an adjustment to increase to the quantity to *SK057 paper, laser printing (each sheet)* from 1 to 3 sheets. The typical CDC Vaccine Information Statement (VIS) is two pages (i.e., one sheet of laser paper, printed double sided). However, the emergency use authorization (EUA) for the Pfizer COVID VIS is 6 pages and the EUA for the Moderna COVID VIS is 5 pages. It is anticipated that the AstraZeneca COVID VIS (and future COVID VIS) will follow suit.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Therefore, the Practice Subcommittee amends the recommendation for SK057 accordingly (i.e., 3 sheets of laser paper, printed double sided) for all COVID IA codes (0001A, 0002A, 0011A, 0012A, 0021A, 0022A and 0031A). The remaining supplies recommended are: SB022 *gloves, non-sterile* to reflect a full pair and exclude any COVID-19 cleaning supplies including additional quantities of hand sanitizer and disinfecting wipes/sprays/cleansers as these are included in CPT code 99072. The PE Subcommittee excluded any supplies that are included in the ancillary supply kit supplied by the Federal Government at no cost to enrolled COVID-19 vaccine providers.

The PE Subcommittee recommends new equipment item *refrigerator, vaccine medical grade, w-data logger sngl glass door,* the same equipment included in the Moderna IA codes (0011A and 0012A). In 2019, there was significant discussion about the existing equipment ED043 *refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates* and whether it was a direct or indirect expense. ED043 is the monitoring system and was retained as a direct expense in accordance with the spreadsheet. The medication-grade refrigerator is used solely to store highly expensive and fragile biologics for use at the time they are needed. Although the medications are stored for longer than the length of the service, it would be extremely difficult to determine typical length of storage as this varies across local sites. The RUC and CMS have a precedent of including refrigerators in direct expense costs and using the total clinical staff time for the equipment minutes, as was done for vaccination codes, including codes 90471, 90472, 90473, and 90474, where the equipment time for the refrigerator is equal to the total clinical staff time. The RUC recommends that the same refrigerator and monitor would be typical medical equipment for the AstraZeneca, Moderna and Janssen vaccines. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Services
The RUC recommends that all COVID Immunization Administration codes (0001A, 0002A, 0011A, 0012A, 0021A, 0022A and 0031A) be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Modifier -51 Exempt
The RUC acknowledges that vaccines and immunizations are inherently precluded from the modifier -51 application and note that the revisions to the CPT guidelines are already in place, which include COVID immunizations.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine Vaccines				
		*(91300-*91303 *Codes are out of numerical sequence. See 90472-90581*)		
Immunization Administration for Vaccines/Toxoids				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Report vaccine immunization administration codes (90460, 90461, 90471-90474, *0001A, 0002A, 0011A, 0012A*, *0021A, 0022A*, 0031A) in addition to the vaccine and toxoid code(s) (90476-90749, *91300, 91301*, *91302,* 91303).

Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient/family during the administration of a vaccine *other than when performed for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccines. For immunization administration of any vaccine, other than (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccines*, that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family/*guardian* or for administration of vaccines to patients over 18 years of age, report codes 90471-90474. (See also **Instructions for Use of the CPT Codebook** for definition of reporting qualifications.)

Report codes 0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A for immunization administration of SARS-CoV-2 (coronavirus disease [COVID-19]) vaccines only. Each administration code is specific to each individual vaccine product (eg, 91300, 91301, 91302, 91303) the dosage schedule (eg, first dose, second dose) and counseling, when performed. The appropriate administration code is chosen based on the type of vaccine and the specific dose number the patient receives in the schedule. For example, code 0012A is be reported for the second dose of vaccine 91301. Do not report codes 90460-90474 for the administration of SARS-CoV-2 (coronavirus disease [COVID-19]) vaccines. Codes related to SARS-CoV-2 (coronavirus disease [COVID-19]) vaccine administration are listed in Appendix Q, with their associated vaccine code descriptors, vaccine administration codes, vaccine manufacturer, vaccine name(s), National Drug Code (NDC) Labeler Product ID, and interval between doses. In order to report these codes, the vaccine must fulfill the code descriptor and must be the vaccine represented by the manufacturer and vaccine name listed in Appendix Q.

If a significant separately identifiable Evaluation and Management service (eg, new or established patient office or other outpatient services [99202-99215], office or other outpatient consultations [99241-99245], emergency department services [99281-99285], preventive medicine services [99381-99429]) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes.

A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism (90460 and 90461). Multi-valent antigens or multiple serotypes of antigens against a single organism are considered a single component of vaccines. Combination vaccines are those vaccines that contain multiple vaccine components. Conjugates or adjuvants contained in vaccines are not considered to be component parts of the vaccine as defined above.

(For allergy testing, see 95004 et seq)

(For skin testing of bacterial, viral, fungal extracts, see 86485-86580)

(For therapeutic or diagnostic injections, see 96372-96379)

90460	*Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered*
+90461	*each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

	(Use 90460 for each vaccine administered. For vaccines with multiple components [combination vaccines], report 90460 in conjunction with 90461 for each additional component in a given vaccine)
	(Do not report 90460, 90461 in conjunction with 91300, 91301, 91302, 91303 *unless both a severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease {COVID-19}] vaccine/toxoid product and at least one vaccine/toxoid product from 90476-90749 are administered at the same encounter)*
90471	*Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*
	(Do not report 90471 in conjunction with 90473)
+90472	*each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)*
	(Use 90472 in conjunction with 90460, 90471, 90473)
	(Do not report 90471, 90472 in conjunction with 91300, 91301, 91302, 91303, *unless both a severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease {COVID-19}] vaccine/toxoid product and at least one vaccine/toxoid product from 90476- 90749 are administered at the same encounter)*
	(For immune globulins, see 90281-90399. For administration of immune globulins, see 96365, 96366, 96367, 96368, 96369, 96370, 96371, 96374)
	(For intravesical administration of BCG vaccine, see 51720, 90586)
90473	*Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)*
	(Do not report 90473 in conjunction with 90471)
+90474	*each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)*
	(Use 90474 in conjunction with 90460, 90471, 90473)
	(Do not report 90473, 90474 in conjunction with 91300, 91301, 91302, 91303, *unless both a severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease {COVID-19}] vaccine/toxoid product and at least one vaccine/toxoid product from 90476- 90749 are administered at the same encounter)*
●0001A	*Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose*

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

●*0002A*		*second dose* *(Report 001A, 0002A for the administration of vaccine 91300)*		
●*0011A*		*Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose*		
●*0012A*		*second dose* *(Report 0011A, 0012A for the administration of vaccine 91301)*		
●0021A	AA1	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; first dose	XXX	0.20
●0022A	AA2	second dose (Report 0021A, 0022A for the administration of vaccine 91302)	XXX	0.20
●0031A	AA1	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, single dose (Report 0031A for the administration of vaccine 91303)	XXX	0.20

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:0021A Tracking Number AA1 Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.20**

CPT Descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease, consistent with evidence-supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified health care professional reviews the patient's chart to confirm that vaccination to decrease the risk of COVID-19 is indicated. The patient is counseled on the benefits and risks of vaccination to decrease the risk of COVID-19 and consent is obtained. The first dose of the COVID-19 vaccine is administered by intramuscular injection in the upper arm. The patient is monitored for any adverse reaction. The patient's immunization record (and registry when applicable) are updated to reflect the vaccine administered.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD; Korinne Van Keuren, DNP, MS, RN					
Specialty Society(ies):	AAFP, ACOG, ACP, AAP, ANA					
CPT Code:	0021A					
Sample Size:	0	**Resp N:**	0			
Description of Sample:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate						
Survey RVW:						
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:			**0.00**			
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	0021A	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90460	XXX	0.20	**RUC Time**

CPT Descriptor Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source

CPT Descriptor

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99406	XXX	0.24	**RUC Time**	532,709

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92081	XXX	0.30	**RUC Time**	92,708

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Other Reference CPT Code	Global	Work RVU	Time Source
90470	XXX	0.20	**RUC Time**

CPT Descriptor H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [SUNSET]

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 **% of respondents:** 0.0 **%**

Number of respondents who choose 2nd Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 0021A	**Top Key Reference CPT Code:** 90460	**2nd Key Reference CPT Code:** ____
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	7.00	7.00	0.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**0.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In response to the COVID-19 pandemic and public health need for rapid deployment of COVID-19 vaccines, RUC was asked to provide resource-based information for immunization administration (IA) for the administration codes specific to these vaccines. This occurred in the same time period that CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services in general, as critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. Prior to this point, CMS has not accepted RUC survey-based

recommendations for IA codes with the one exception of the value for CPT code 90470 -- immunization administration for the pandemic H1N1 vaccine in 2009. The value for CPT code 90470 was a crosswalk to the RUC-approved value for CPT code 90460 at the same RUC meeting because the timing of the H1N1 vaccine need did not allow for a separate survey. The CPT code 90470 was viewed as temporary for the pandemic; however, the source for the CPT code 90470 wRVU remains in the RUC database for CPT code 90460. This expert panel therefore believes that the physician work for the COVID IA is the same as the RUC recommended work for CPT code 90460 (and CPT code 90470).

For CPT code 0021A, we recommend a crosswalk to December 2020 RUC-recommended work relative value units (0.20 wRVUs) and intraservice time (7 minutes) for CPT code 0011A (Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose), which was crosswalked from October 2009 RUC-recommended work relative value units (0.20 wRVUs) and intraservice time (7 minutes) for CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A; this is a new service

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90460

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:0022A Tracking Number AA2 Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.20**

CPT Descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; second dose

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease, consistent with evidence-supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified health care professional reviews the patient's chart to confirm that vaccination to decrease the risk of COVID-19 is indicated. The patient is counseled on the benefits and risks of vaccination to decrease the risk of COVID-19 and consent is obtained. The second dose of the COVID-19 vaccine is administered by intramuscular injection in the upper arm. The patient is monitored for any adverse reaction. The patient's immunization record (and registry when applicable) are updated to reflect the vaccine administered.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2021					
Presenter(s):	Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD; Korinne Van Keuren, DNP, MS, RN					
Specialty Society(ies):	AAFP, ACOG, ACP, AAP, ANA					
CPT Code:	0022A					
Sample Size:	0	**Resp N:**	0			
Description of Sample:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate						
Survey RVW:						
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:			**0.00**			
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	0022A	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90460	XXX	0.20	**RUC Time**

CPT Descriptor Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source

CPT Descriptor

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99406	XXX	0.24	**RUC Time**	532,709

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92081	XXX	0.30	**RUC Time**	92,708

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Other Reference CPT Code	Global	Work RVU	Time Source
90470	XXX	0.20	**RUC Time**

CPT Descriptor H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [SUNSET]

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 **% of respondents:** 0.0 **%**

Number of respondents who choose 2nd Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 0022A	**Top Key Reference CPT Code:** 90460	**2nd Key Reference CPT Code:** ____
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	7.00	7.00	0.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**0.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In response to the COVID-19 pandemic and public health need for rapid deployment of COVID-19 vaccines, RUC was asked to provide resource-based information for immunization administration (IA) for the administration codes specific to these vaccines. This occurred in the same time period that CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services in general, as critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. Prior to this point, CMS has not accepted RUC survey-based

recommendations for IA codes with the one exception of the value for CPT code 90470 -- immunization administration for the pandemic H1N1 vaccine in 2009. The value for CPT code 90470 was a crosswalk to the RUC-approved value for CPT code 90460 at the same RUC meeting because the timing of the H1N1 vaccine need did not allow for a separate survey. The CPT code 90470 was viewed as temporary for the pandemic; however, the source for the CPT code 90470 wRVU remains in the RUC database for CPT code 90460. This expert panel therefore believes that the physician work for the COVID IA is the same as the RUC recommended work for CPT code 90460 (and CPT code 90470).

For CPT code 0022A, we recommend a crosswalk to December 2020 RUC-recommended work relative value units (0.20 wRVUs) and intraservice time (7 minutes) for CPT code 0012A (Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose), which was crosswalked from October 2009 RUC-recommended work relative value units (0.20 wRVUs) and intraservice time (7 minutes) for CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A; this is a new service

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90460

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:0031A Tracking Number AA1 Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU:
Global Period: XXX Current Work RVU: RUC Recommended RVU:

CPT Descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage, single dose

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease, consistent with evidence-supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified health care professional reviews the patient's chart to confirm that vaccination to decrease the risk of COVID-19 is indicated. The patient is counseled on the benefits and risks of vaccination to decrease the risk of COVID-19 and consent is obtained. The single dose of the COVID-19 vaccine is administered by intramuscular injection in the upper arm. The patient is monitored for any adverse reaction. The patient's immunization record (and registry when applicable) are updated to reflect the vaccine administered.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD					
Specialty Society(ies):	AAFP, ACOG, ACP, AAP					
CPT Code:	0031A					
Sample Size:	0	**Resp N:**	0			
Description of Sample:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate						
Survey RVW:						
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:			**0.00**			
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	0031A	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90460	XXX	0.20	**RUC Time**

CPT Descriptor Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source

CPT Descriptor

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99406	XXX	0.24	**RUC Time**	532,709

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92081	XXX	0.30	**RUC Time**	92,708

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Other Reference CPT Code	Global	Work RVU	Time Source
90470	XXX	0.20	**RUC Time**

CPT Descriptor H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [SUNSET]

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 **% of respondents:** 0.0 **%**

Number of respondents who choose 2nd Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 0031A	**Top Key Reference CPT Code:** 90460	**2nd Key Reference CPT Code:** ____
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	7.00	7.00	0.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**0.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In response to the COVID-19 pandemic and public health need for rapid deployment of COVID-19 vaccines, RUC was asked to provide resource-based information for immunization administration (IA) for the administration codes specific to these vaccines. This occurred in the same time period that CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services in general, as critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. Prior to this point, CMS has not accepted RUC survey-based

recommendations for IA codes with the one exception of the value for CPT code 90470 -- immunization administration for the pandemic H1N1 vaccine in 2009. The value for CPT code 90470 was a crosswalk to the RUC-approved value for CPT code 90460 at the same RUC meeting because the timing of the H1N1 vaccine need did not allow for a separate survey. The CPT code 90470 was viewed as temporary for the pandemic; however, the source for the CPT code 90470 wRVU remains in the RUC database for CPT code 90460. This expert panel therefore believes that the physician work for the COVID IA is the same as the RUC recommended work for CPT code 90460 (and CPT code 90470).

For CPT code 0031A, we recommend a crosswalk to the January 2021 RUC-recommended work relative value units (0.20 wRVUs) and intraservice time (7 minutes) for CPT code 0021A (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; first dose
NOTE: CPT code 0021A was crosswalked from the December 2020 RUC-recommended work relative value units (0.20 wRVUs) and intraservice time (7 minutes) for CPT code 0011A (Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose)
NOTE: CPT code 0011A was crosswalked from the October 2009 RUC-recommended work relative value units (0.20 wRVUs) and intraservice time (7 minutes) for CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered)

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A; this is a new service

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
Specialty	How often?
Specialty	How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90460

SS Rec Summary

ISSUE: AstraZeneca COVID Immunization Administration

TAB: 34

Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF RUC REC 2009	90460	XXX	Immunization administration through 18 years of age via any route of administration, with		0.029	0.029			0.20			7						7			
2021 CMS	90460	XXX	Immunization administration through 18 years of age via any		0.024	0.024			0.17			7						7			
	96411	ZZZ	Chemotherapy administration; intravenous, push technique,		0.033	0.029			0.20			7	3					4			
	99188	XXX	Application of topical fluoride varnish by a physician or other		0.022	0.022			0.20			9	2					5			2
	96365	XXX	Intravenous infusion, for therapy, prophylaxis, or		0.024	0.023			0.21			9	2					5			2
December 2020 RUC	0011A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			
December 2020 RUC	0012A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			
REC	0021A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			
REC	0022A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

1st REF = Top Key Reference code data

2st REF = Second Highest Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Janssen COVID Immunization Administration

TAB:

								RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
1st REF RUC REC 2009	90460	XXX	Immunization administration through 18 years of age via any		0.029	0.029			0.20			7						7			
2021 CMS	90460	XXX	Immunization administration through 18 years of age via any		0.024	0.024			0.17			7						7			
	96411	ZZZ	Chemotherapy administration; intravenous, push technique,		0.033	0.029			0.20			7	3					4			
	99188	XXX	Application of topical fluoride varnish by a physician or other		0.022	0.022			0.20			9	2					5			2
	96365	XXX	Intravenous infusion, for therapy, prophylaxis, or		0.024	0.023			0.21			9	2					5			2
December 2020 RUC	0011A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			
January 2021 RUC	0021A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			
REC	0031A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):0021A-0022A**

SPECIALTY SOCIETY(IES): AAFP, ACOG, ACP, AAP, ANA

PRESENTER(S): Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD; Korinne Van Keuren, DNP, MS, RN

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: January 2021

CPT Code	Long Descriptor	Global Period
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; first dose	XXX
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; second dose	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
0021A	A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.
0022A	A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   RUC Advisors from AAFP, ACOG, ACP, ANA, and AAP acted as an expert panel and met by video conferencing, phone, and email to develop the recommended direct PE inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   We are utilizing CPT codes 0011A (Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose) and 0012A (Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100

mcg/0.5mL dosage; second dose) as our crosswalk codes, which utilize CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered) as their base reference code due to the inherent similarity between the service described by 90460 and the COVID Immunization Administration (IA) codes. To the base of 90460 direct PE inputs, we are recommending incremental direct PE inputs as required by public health emergency (PHE) regulations for administering the pandemic COVID vaccine.
Additionally, to the December 2020 RUC direct PE inputs for 0001A-0002A and 0011A-0012A (and, accordingly, 0021A-0022A), we are recommending one amendment: 3 sheets of laser printer paper (SK057) instead of 1 sheet of laser printer paper.
Rationale: The typical CDC Vaccine Information Sheet (VIS) is two pages (ie, one sheet of laser paper, printed double sided). However, the EUA for the Pfizer COVID VIS is 6 pages and the EUA for the Moderna COVID VIS is 5 pages (please see: https://www.fda.gov/media/144414/download and https://www.fda.gov/media/144638/download**). It is anticipated that the AstraZeneca COVID VIS (and future COVID VIS) will follow suit. Therefore, we are amending our recommendation for SK057 accordingly (ie, three sheets of laser paper, printed double sided).**

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No and no. The typical patient will not be seen for an E/M service as the COVID vaccine is being administered in response to its pandemic status.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   CPT code 90460: Family Medicine; 46%; no.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   CA033: The additional minutes (7 minutes for 0021A; 5 minutes for 0022A) reflect 1 minute for manually filling out the vaccine card required to be given to the patient plus another 6 minutes (for 0021A) or 4 minutes (for 0022A) of logging required information into the registry (eg, IIS, VAMS) and maintaining vaccine refrigerator/freezer temperature logs. The typical patient is an adult who will need new record creation in IIS for 0021A, which typically takes 2 minutes to create and enter demographic information. New record creation will not be needed for the second dose given 21-28 days later (0022A). Therefore, the 6 minutes for 0021A reflects patient record creation and demographic entry (2 minutes) plus the actual vaccine information logging time and maintenance of vaccine refrigerator/freezer temperature logs (4 minutes). The 4 minutes for 0022A reflects only the actual vaccine information logging time and maintenance of vaccine refrigerator/freezer temperature logs (4 minutes).
   CA034: The individual (RN/LPN/MTA) who performs the actual vaccine administration must be the person who documents the procedure in the patient's medical record (ie, "the person who did it documents it, and

the person who documented it did it"). The 3 minutes is the same for both dose one (0021A) and dose two (0022A).

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

As a result of the COVID pandemic and vaccine emergency use authorization (EUA) status, administration of the COVID vaccine has direct PE inputs over and above those required for "regular" immunization administration, which cannot be entirely accounted for due to an increase in physician time:

- Vaccine inventory specific to limited distribution of COVID vaccine (ie, account for every dose given, wastage and spoilage reports) (1 minute to CA008)
- Identify and contact appropriate patients and schedule immunization (2 minutes for 0021A only to CA005)
- Due to risk of anaphylaxis with COVID vaccine, post-procedure monitoring multitasking 1:4 (4 minutes to CA022)
- Providing patient with paper vaccine card (1 minute to CA033)
- Enter additional data into immunization information system (IIS) as required by state and federal regulations (6 minutes for 0021A and 4 minutes for 0022A to CA033)
- Use of a **vaccine medical grade refrigerator (NEW, line 111)** (100% of IS CST for 0021A and 0022A)
- Each refrigerator requires a **temperature monitor with alarm (ED043, line 107)**, which is accounted for in the total minutes for the vaccine medical grade refrigerator (NEW, line 111)

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Prepare patient chart with appropriate CDC VIS: Rolled into CA001
Provide patient/parent with appropriate CDC VIS: Rolled into CA012
Clinical staff (RN/LPN/MTA) enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.: Rolled into CA034
Clinical staff (Medical/Technical Assistant) enters data into the state online immunization information system (IIS) (registry) and maintains the vaccine refrigerator/freezer temperature logs.: Rolled into CA033

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

We allocated 0 minutes to obtain vital signs and, therefore, are requesting no CST.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Complete pre-service diagnostic and referral forms (ie, prepare patient chart with appropriate CDC VIS); Complete pre-procedure phone calls and prescription (ie, identify and contact appropriate patients and schedule immunization (0021A only)); Perform regulatory mandated quality assurance activity (ie, vaccine inventory specific to limited distribution of COVID vaccine (ie, account for every dose given, wastage and spoilage reports).

b. Service period (includes pre, intra and post):

Greet patient, provide gowning, ensure appropriate medical records; Provide education and obtain consent; Review requisition, assess for special needs (ie, provide patient/parent with appropriate CDC VIS); Prepare room, equipment, and supplies; Monitor patient following procedure; Clean room/equipment; Enter vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law; Enter additional data as required by state and federal regulations into the state online immunization information system (IIS) (registry); Maintain the vaccine refrigerator/freezer temperature log; Provide required paper card and information sheet to patient.

c. Post-service period:

Conduct patient communication.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

RN/LPN/MTA prepares the vaccine, instructs the patient (or parent) on proper positioning, selects and prepares the injection site, administers the vaccine, and applies a bandage to the injection site. The patient is then monitored for potential anaphylaxis response to the vaccine.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

While *identify and contact appropriate patients and schedule immunization* was originally assigned to Row 26 NEW, it was subsequently moved to CA005 during the December 2020 RUC/PE Subcommittee meeting. This is required by the CDC and local public health as the COVID vaccine will be delivered in tiers (2 minutes for 0021A only).

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

McKesson redacted invoice attached, includes estimate for refrigerator, vaccine medical grade, w-data logger sngl glass door ($7,674.43) (NEW, line 111)

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

10 years

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Formula: Default Refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates (SD043) Refrigerator, vaccine medical grade, w-data logger sngl glass door (NEW) ($7,674.43)

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

Please note under Medical Equipment: Line 107 (SD043): While its description begins with "refrigerator, vaccine," it is the **temperature monitor with alarm** for the vaccine medical grade refrigerator (NEW, line 111).

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):0031A**

SPECIALTY SOCIETY(IES): AAFP, ACOG, ACP, AAP

PRESENTER(S): Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April 2021

CPT Code	Long Descriptor	Global Period
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, single dose	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
0031A	A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   RUC Advisors from AAFP, ACOG, ACP, and AAP acted as an expert panel and met by video conferencing, phone, and email to develop the recommended direct PE inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   We are utilizing CPT code 0021A (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; first dose) as our crosswalk code, which utilizes CPT code 0011A (Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose) as its crosswalk code, with one exception: CPT code 0021A includes 3 sheets of laser printer paper (SK057) instead of 1 sheet of laser printer paper.
   Rationale: The typical CDC Vaccine Information Sheet (VIS) is two pages (ie, one sheet of laser paper, printed double sided). However, the EUA for the Pfizer COVID VIS is 6 pages and the EUA for the Moderna COVID VIS is 5 pages (please see: https://www.fda.gov/media/144414/download and https://www.fda.gov/media/144638/download). It is anticipated that the AstraZeneca COVID VIS (and future COVID VIS) will follow suit. Therefore, we are amending our recommendation for SK057 accordingly (ie, three sheets of laser paper, printed double sided).
   The base reference code to all COVID Immunization Administration (IA) codes (0001A-0002A, 0011A-0012A, 0021A-0022A, 0031A) is CPT code 90460 (Immunization administration through 18 years of age

via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered) as its base reference code due to the inherent similarity between the service described by 90460 and the COVID IA codes. To the base of 90460 direct PE inputs, we are recommending incremental direct PE inputs as required by public health emergency (PHE) regulations for administering the pandemic COVID vaccine.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No and no. The typical patient will not be seen for an E/M service as the COVID vaccine is being administered in response to its pandemic status.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   CPT code 90460: Family Medicine; 46%; no.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   CA033: The additional minutes (7 minutes for 0031A) reflect 1 minute for manually filling out the vaccine card required to be given to the patient plus another 6 minutes of logging required information into the registry (eg, IIS, VAMS) and maintaining vaccine refrigerator/freezer temperature logs. The typical patient is an adult who will need new record creation in IIS for 0031A, which typically takes 2 minutes to create and enter demographic information. Therefore, the 6 minutes for 0031A reflects patient record creation and demographic entry (2 minutes) plus the actual vaccine information logging time and maintenance of vaccine refrigerator/freezer temperature logs (4 minutes).
   CA034: The individual (RN/LPN/MTA) who performs the actual vaccine administration must be the person who documents the procedure in the patient's medical record (ie, "the person who did it documents it, and the person who documented it did it") (3 minutes for 0031A).

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   As a result of the COVID pandemic and vaccine emergency use authorization (EUA) status, administration of the COVID vaccine has direct PE inputs over and above those required for "regular" immunization administration, which cannot be entirely accounted for due to an increase in physician time:
   - Vaccine inventory specific to limited distribution of COVID vaccine (ie, account for every dose given, wastage and spoilage reports) (1 minute to CA008)
   - Identify and contact appropriate patients and schedule immunization (2 minutes for 0031A to CA005)

- Due to risk of anaphylaxis with COVID vaccine, post-procedure monitoring multitasking 1:4 (4 minutes to CA022)
- Providing patient with paper vaccine card (1 minute to CA033)
- Enter additional data into immunization information system (IIS) as required by state and federal regulations (6 minutes for 0031A to CA033)
- Use of a **vaccine medical grade refrigerator (NEW, line 111)** (100% of IS CST for 0031A)
- Each refrigerator requires a **temperature monitor with alarm (ED043, line 107)**, which is accounted for in the total minutes for the vaccine medical grade refrigerator (NEW, line 111)

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Prepare patient chart with appropriate CDC VIS: Rolled into CA001
Provide patient/parent with appropriate CDC VIS: Rolled into CA012
Clinical staff (RN/LPN/MTA) enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.: Rolled into CA034
Clinical staff (Medical/Technical Assistant) enters data into the state online immunization information system (IIS) (registry) and maintains the vaccine refrigerator/freezer temperature logs.: Rolled into CA033

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

We allocated 0 minutes to obtain vital signs and, therefore, are requesting no CST.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Complete pre-service diagnostic and referral forms (ie, prepare patient chart with appropriate CDC VIS); Complete pre-procedure phone calls and prescription (ie, identify and contact appropriate patients and schedule immunization); Perform regulatory mandated quality assurance activity (ie, vaccine inventory specific to limited distribution of COVID vaccine (ie, account for every dose given, wastage and spoilage reports).

   b. Service period (includes pre, intra and post):

Greet patient, provide gowning, ensure appropriate medical records; Provide education and obtain consent; Review requisition, assess for special needs (ie, provide patient/parent with appropriate CDC VIS); Prepare room, equipment, and supplies; Monitor patient following procedure; Clean room/equipment; Enter vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law; Enter additional data as required by state and federal regulations into the state online immunization information system (IIS) (registry); Maintain the vaccine refrigerator/freezer temperature log; Provide required paper card and information sheet to patient.

   c. Post-service period:

Conduct patient communication.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

RN/LPN/MTA prepares the vaccine, instructs the patient (or parent) on proper positioning, selects and prepares the injection site, administers the vaccine, and applies a bandage to the injection site. The patient is then monitored for potential anaphylaxis response to the vaccine.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

While *identify and contact appropriate patients and schedule immunization* was originally assigned to Row 26 NEW, it was subsequently moved to CA005 during the December 2020 RUC/PE Subcommittee meeting. This is required by the CDC and local public health as the COVID vaccine will be delivered in tiers (2 minutes for 0031A).

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

McKesson redacted invoice attached, includes estimate for refrigerator, vaccine medical grade, w-data logger sngl glass door ($7,674.43) (NEW, line 111)

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

10 years

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Formula: Default
Refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates (SD043)
Refrigerator, vaccine medical grade, w-data logger sngl glass door (NEW) ($7,674.43)

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

Please note under Medical Equipment:
Line 107 (SD043): While its description begins with "refrigerator, vaccine," it is the **temperature monitor with alarm** for the vaccine medical grade refrigerator (NEW, line 111).

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet

during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K	L	M
1	RUC Practice Expense Spreadsheet					REFERENCE CODE		REFERENCE CODE		RECOMMENDED		RECOMM
2						90460		99072		0001A		000
3		*RUC Collaboration Website*				October 2009		Sept 2020		Immunization		Immun
4	Clinical Activity Code	Meeting Date: January 2021 Revision Date (if applicable): Tab: Janssen COVID Immunization Administration Specialties: AAFP, ACOG, ACP, AAP	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Immunization administration through 18 years of age via any route of		Additional supplies, materials, and clinical staff time over and above		Immunization administration by intramuscular injection of severe acute respiratory		Immun administ intram injection acute re
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD										
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 7.82	$ 0.37	$ 6.36	$ -	$ 15.18	$ -	$ 13.76
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	18.0	1.0	11.0	0.0	37.0	0.0	33.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	1.0	0.0	3.0	0.0	4.0	0.0	2.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	16.0	0.0	8.0	0.0	30.0	0.0	28.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	1.0	1.0	0.0	0.0	3.0	0.0	3.0
12		~~TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE~~				$ 6.66	$ 0.37	$ 4.07	$ -	$ 12.92	$ -	$ 11.66
13		PRE-SERVICE PERIOD										
14		Start: Following visit when decision for surgery/procedure made										
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37					1		1
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37							
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37							
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37							
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37			3		2		0
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37							
21	CA007	Review patient clinical extant information and	L037D	RN/LPN/MTA	0.37							
22	CA008	Perform regulatory mandated quality assurance activity	L037D	RN/LPN/MTA	0.37					1		1
26	OLD	Prepare patient chart with appropriate CDC VIS	L037D	RN/LPN/MTA	0.37	1						
27		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37							
28		End: When patient enters office/facility for surgery/procedure										
29		SERVICE PERIOD										
30		Start: When patient enters office/facility for surgery/procedure:										
31		Pre-Service (of service period)										
32	CA009	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	0.37					3		3
33	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37			1		0		0
34	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37	3				3		3
35	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37					1		1
36	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37			2		2		2
37	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37							
38	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37							
39	CA016	Prepare, set-up and start IV, initial positioning and	L037D	RN/LPN/MTA	0.37							
40	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37							
45		Intra-service (of service period)										
46	CA018	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37							
47	CA019	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37							
48	CA020	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37							
49	CA021	Perform procedure/service---NOT directly related to	L037D	RN/LPN/MTA	0.37	4				4		4
54	OLD	Provide patient/parent with appropriate CDC VIS	L037D	RN/LPN/MTA	0.37	1						
56		Post-Service (of service period)										
57	CA022	Monitor patient following procedure/service, multitasking	L037D	RN/LPN/MTA	0.37					4		4
58	CA023	Monitor patient following procedure/service, no	L037D	RN/LPN/MTA	0.37							
59	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	1		5		3		3
60	CA025	Clean scope	L037D	RN/LPN/MTA	0.37							
61	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37							
62	CA027	Complete post-procedure diagnostic forms, lab and x-	L037D	RN/LPN/MTA	0.37							
63	CA028	Review/read post-procedure x-ray, lab and pathology	L037D	RN/LPN/MTA	0.37							
64	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37							
65	CA030	Technologist QC's images in PACS, checking for all	L037D	RN/LPN/MTA	0.37							
66	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37							
67	CA032	Scan exam documents into PACS. Complete exam in	L037D	RN/LPN/MTA	0.37							
68	CA033	Perform regulatory mandated quality assurance activity	L026A	Medical/Tech	0.26					7		5
69	CA034	Document procedure (nonPACS) (e.g. mandated	L037D	RN/LPN/MTA	0.37					3		3
70	CA035	Review home care instructions, coordinate	L037D	RN/LPN/MTA	0.37							
71	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a		n/a		n/a		n/a
74	OLD	Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.	L037D	RN/LPN/MTA	0.37	3						
75	OLD	Clinical staff enters data into the state online immunization information system (IIS) (registry) and maintains the vaccine refrigerator/freezer temperature log.	L037D	RN/LPN/MTA	0.37	4						
76		End: Patient leaves office/facility	L037D	RN/LPN/MTA	0.37							
77		POST-SERVICE PERIOD										
78		Start: Patient leaves office/facility										
79	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37	1	1			3	0	3
80	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37							
81		*Office visits: List Number and Level of Office Visits*	MINUTES			# visits	# visits	# visits	# visits	# visits	# visits	# visits
82		99211 16 minutes	16									
83		99212 27 minutes	27									
84		99213 36 minutes	36									
85		99214 53 minutes	53									
86		99215 63 minutes	63									
87	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	0.0	0.0	0.0
88			L037D	RN/LPN/MTA	0.37							
91		*Other activity: please include short clinical description*	L037D	RN/LPN/MTA	0.37							
94		End: with last office visit before end of global period										

	A	B	D	E	F	G	H	I	J	K	L	M
1	RUC Practice Expense Spreadsheet					REFERENCE CODE		REFERENCE CODE		RECOMMENDED		RECOMM
2						90460		99072		0001A		000
3		*RUC Collaboration Website*				October 2009		Sept 2020		Immunization		Immun
4	Clinical Activity Code	Meeting Date: January 2021 Revision Date (if applicable): Tab: Janssen COVID Immunization Administration Specialties: AAFP, ACOG, ACP, AAP	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Immunization administration through 18 years of age via any route of		Additional supplies, materials, and clinical staff time over and above		Immunization administration by intramuscular injection of severe acute respiratory		administ intram injection acute re
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD										
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 7.82	$ 0.37	$ 6.36	$ -	$ 15.18	$ -	$ 13.76
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	18.0	1.0	11.0	0.0	37.0	0.0	33.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	1.0	0.0	3.0	0.0	4.0	0.0	2.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	16.0	0.0	8.0	0.0	30.0	0.0	28.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	1.0	1.0	0.0	0.0	3.0	0.0	3.0
95	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT								
96		TOTAL COST OF SUPPLY QUANTITY x PRICE				$ 1.00	$ -	$ 2.29	$ -	$ 0.61	$ -	$ 0.61
97	SB033	mask, surgical	0.43	item				3		0		0
98	SC058	syringe w-needle, OSHA compliant (SafetyGlide)	0.4762	item		1				0		0
99	SJ053	swab-pad, alcohol	0.0333	item		2				0		0
100	SB022	gloves, non-sterile	0.246	pair		0.5				1.0		1.0
101	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.3182	item		1				1		1
102	SK057	paper, laser printing (each sheet)	0.0163	item		1				3		3
103	NEW	*Covid-19 Cleaning Supplies including additional quantities of hand sanitizer and disinfecting wipes/sprays/cleansers*	1	computed per patient				1		0		0
105	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute							
106		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				$ 0.16	$ -	$ -	$ -	$ 1.65	$ -	$ 1.49
107	ED043	refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates	1000		0.002653727	16				37		33
108	EF040	refrigerator, vaccine, commercial grade, w-alarm lock	2672.233		0.007091376	16						
111	NEW	refrigerator, vaccine medical grade, w-data logger sngl glass door	7674.43	Default	0.020365838					3		2
112	NEW	freezer, under counter, ultra cold 3.7 cu ft	16,516.36	Default	0.043829902					34		31

	A	B	N	O	P	Q	R	S	T	U	V	W	X
1	RUC Practice Expense Spreadsheet		MENDED	RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2			02A	0011A		0012A		0021A		0022A		0031A	
3		*RUC Collaboration Website*	ization	Immunization		Immunization		Immunization		Immunization		Immunization	
4	Clinical Activity Code	Meeting Date: January 2021 Revision Date (if applicable): Tab: Janssen COVID Immunization Administration Specialties: AAFP, ACOG, ACP, AAP	ration by uscular of severe spiratory	administration by intramuscular injection of Severe acute respiratory		administration by intramuscular injection of Severe acute respiratory		administration by intramuscular injection of severe acute respiratory		administration by intramuscular injection of severe acute respiratory		administration by intramuscular injection of severe acute respiratory	
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD											
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ 14.38	$ -	$ 13.03	$ -	$ 14.38	$ -	$ 13.03	$ -	$ 14.38	$ -
8		TOTAL CLINICAL STAFF TIME	0.0	37.0	0.0	33.0	0.0	37.0	0.0	33.0	0.0	37.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	4.0	0.0	2.0	0.0	4.0	0.0	2.0	0.0	4.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	30.0	0.0	28.0	0.0	30.0	0.0	28.0	0.0	30.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	3.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ -	$ 12.92	$ -	$ 11.66	$ -	$ 12.92	$ -	$ 11.66	$ -	$ 12.92	$ -
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery/procedure											
15	CA001	Complete pre-service diagnostic and referral forms		1		1		1		1		1	
16	CA002	Coordinate pre-surgery services (including test results)											
17	CA003	Schedule space and equipment in facility											
18	CA004	Provide pre-service education/obtain consent											
19	CA005	Complete pre-procedure phone calls and prescription		2		0		2		0		2	
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance activity		1		1		1		1		1	
26	OLD	Prepare patient chart with appropriate CDC VIS											
27		*Other activity: please include short clinical description here and type new in column A*											
28		End: When patient enters office/facility for surgery/procedu											
29		SERVICE PERIOD											
30		Start: When patient enters office/facility for surgery/proced											
31		Pre-Service (of service period)											
32	CA009	Greet patient, provide gowning, ensure appropriate		3		3		3		3		3	
33	CA010	Obtain vital signs		0		0		0		0		0	
34	CA011	Provide education/obtain consent		3		3		3		3		3	
35	CA012	Review requisition, assess for special needs		1		1		1		1		1	
36	CA013	Prepare room, equipment and supplies		2		2		2		2		2	
37	CA014	Confirm order, protocol exam											
38	CA015	Setup scope (nonfacility setting only)											
39	CA016	Prepare, set-up and start IV, initial positioning and											
40	CA017	Sedate/apply anesthesia											
45		Intra-service (of service period)											
46	CA018	Assist physician or other qualified healthcare											
47	CA019	Assist physician or other qualified healthcare											
48	CA020	Assist physician or other qualified healthcare											
49	CA021	Perform procedure/service---NOT directly related to		4		4		4		4		4	
54	OLD	Provide patient/parent with appropriate CDC VIS											
56		Post-Service (of service period)											
57	CA022	Monitor patient following procedure/service, multitasking		4		4		4		4		4	
58	CA023	Monitor patient following procedure/service, no											
59	CA024	Clean room/equipment by clinical staff		3		3		3		3		3	
60	CA025	Clean scope											
61	CA026	Clean surgical instrument package											
62	CA027	Complete post-procedure diagnostic forms, lab and x-											
63	CA028	Review/read post-procedure x-ray, lab and pathology											
64	CA029	Check dressings, catheters, wounds											
65	CA030	Technologist QC's images in PACS, checking for all											
66	CA031	Review examination with interpreting MD/DO											
67	CA032	Scan exam documents into PACS. Complete exam in											
68	CA033	Perform regulatory mandated quality assurance activity		7		5		7		5		7	
69	CA034	Document procedure (nonPACS) (e.g. mandated		3		3		3		3		3	
70	CA035	Review home care instructions, coordinate											
71	CA036	Discharge day management		n/a		n/a		n/a		n/a		n/a	
74	OLD	Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.											
75	OLD	Clinical staff enters data into the state online immunization information system (IIS) (registry) and maintains the vaccine refrigerator/freezer temperature log.											
76		End: Patient leaves office/facility											
77		POST-SERVICE PERIOD											
78		Start: Patient leaves office/facility											
79	CA037	Conduct patient communications	0	3	0	3	0	3	0	3	0	3	0
80	CA038	Coordinate post-procedure services											
81		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
82		99211 16 minutes											
83		99212 27 minutes											
84		99213 36 minutes											
85		99214 53 minutes											
86		99215 63 minutes											
87	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
88													
91		*Other activity: please include short clinical description*											
94		End: with last office visit before end of global period											

	A	B	N	O	P	Q	R	S	T	U	V	W	X
1	RUC Practice Expense Spreadsheet		MENDED	RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2			02A	0011A		0012A		0021A		0022A		0031A	
3		*RUC Collaboration Website*	ization	Immunization		Immunization		Immunization		Immunization		Immunization	
4	Clinical Activity Code	Meeting Date: January 2021 Revision Date (if applicable): Tab: Janssen COVID Immunization Administration Specialties: AAFP, ACOG, ACP, AAP	ration by uscular of severe spiratory	administration by intramuscular injection of Severe acute respiratory		administration by intramuscular injection of Severe acute respiratory		administration by intramuscular injection of severe acute respiratory		administration by intramuscular injection of severe acute respiratory		administration by intramuscular injection of severe acute respiratory	
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD											
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ 14.38	$ -	$ 13.03	$ -	$ 14.38	$ -	$ 13.03	$ -	$ 14.38	$ -
8		TOTAL CLINICAL STAFF TIME	0.0	37.0	0.0	33.0	0.0	37.0	0.0	33.0	0.0	37.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	4.0	0.0	2.0	0.0	4.0	0.0	2.0	0.0	4.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	30.0	0.0	28.0	0.0	30.0	0.0	28.0	0.0	30.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	3.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0
95	Supply Code	MEDICAL SUPPLIES											
96		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ 0.61	$ -	$ 0.61	$ -	$ 0.61	$ -	$ 0.61	$ -	$ 0.61	$ -
97	SB033	mask, surgical		0		0		0		0		0	
98	SC058	syringe w-needle, OSHA compliant (SafetyGlide)		0		0		0		0		0	
99	SJ053	swab-pad, alcohol		0		0		0		0		0	
100	SB022	gloves, non-sterile		1.0		1.0		1.0		1.0		1.0	
101	SG021	bandage, strip 0.75in x 3in (Bandaid)		1		1		1		1		1	
102	SK057	paper, laser printing (each sheet)		3		3		3		3		3	
103	NEW	*Covid-19 Cleaning Supplies including additional quantities of hand sanitizer and disinfecting wipes/sprays/cleansers*		0		0		0		0		0	
105	Equipment Code	EQUIPMENT											
106		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ 0.85	$ -	$ 0.76	$ -	$ 0.85	$ -	$ 0.76	$ -	$ 0.85	$ -
107	ED043	refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates		37		33		37		33		37	
108	EF040	refrigerator, vaccine, commercial grade, w-alarm lock											
111	NEW	refrigerator, vaccine medical grade, w-data logger sngl glass door		37		33		37		33		37	
112	NEW	freezer, under counter, ultra cold 3.7 cu ft											

Appendix Q: Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) Vaccines

This table links the individual severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine product codes (91300, 91301, 91302, 91303) to their associated immunization administration codes (0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A), manufacturer name, vaccine name(s), 10 and 11-digit National Drug Code (NDC) Labeler Product ID, and interval between doses. These codes are also located in the Medicine section of the CPT code set.

Additional introductory and instructional information for codes 0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A, 91300, 91301, 91302, and 91303 can be found in the Immunization Administration for Vaccines/Toxoids and Vaccines, Toxoids guidelines in the Medicine section of the CPT code set.

Vaccine Code	Vaccine Code Descriptor	Vaccine Administration Code(s)	Vaccine Manufacturer	Vaccine Name(s)	NDC 10/NDC 11 Labeler Product ID (Vial)	Dosing Interval
91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use	0001A (1st dose) 0002A (2nd dose)	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine	59267-1000-1 59267-1000-01	21 days
91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use	0011A (1st dose) 0012A (2nd dose)	Moderna, Inc	Moderna COVID-19 Vaccine	80777-273-10 80777-0273-10	28 days
91302	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, for intramuscular use	0021A (1st Dose) 0022A (2nd Dose)	AstraZeneca, Plc	AstraZeneca COVID-19 Vaccine	0310-1222-10 00310-1222-10	28 Days

Vaccine Code	Vaccine Code Descriptor	Vaccine Administration Code(s)	Vaccine Manufacturer	Vaccine Name(s)	NDC 10/NDC 11 Labeler Product ID (Vial)	Dosing Interval
91303	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, for intramuscular use	0031A (Single dose)	Janssen	Janssen COVID-19 Vaccine	59676-580-05 59676-0580-05	Not applicable

AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
t (312) 464-5000

December 17, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Attention: CMS-9912-IFC

Subject: RUC Recommendations on COVID-19 Immunization Administration

Dear Administrator Verma:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to submit the enclosed recommendations for work relative values and direct practice expense inputs to the Centers for Medicare & Medicaid Services (CMS). These recommendations relate the four new codes created (0001A, 0002A, 0011A and 0012A) that describe immunization administration (IA) by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines.

The RUC intends to review all other immunization administration codes (90460, 90461, 90471, 90472, 90473, 90474, G0008, G0009 and G0010) in April 2021. Please note that the direct inputs for CPT code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid*) are incorrect in the *CY 2021 PFS Final Rule Direct PE Inputs* and should instead reflect the direct practice expense inputs that are listed for 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered*. Currently, CPT code 90471 has **no supply inputs** listed and only 4 minutes clinical staff time.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at (312) 464-5604.

Sincerely,



Peter K. Smith, MD

Enclosures
cc: RUC Participants
Perry Alexion, MD
Edith Hambrick, MD
Gift Tee
Karen Nakano, MD
Michael Soracoe

AMA/Specialty Society RVS Update Committee Summary of Recommendations

December 2020

SARS-CoV-2-Immunization Administration for Vaccines/Toxoids

On November 5, 2020, the CPT Editorial Panel created four codes to describe immunization administration (IA) by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. CPT codes 0001A and 0002A are used to report the first and second dose administration of the Pfizer-BioNTech COVID-19 vaccine (ie 30 mcg/0.3mL dosage, diluent reconstituted). CPT codes 0011A and 0012A are used to report the first and second dose administration of the Moderna COVID-19 vaccine (ie 100 mcg/0.5mL dosage). These CPT codes, developed based on extensive collaboration with CMS and the CDC, are unique for each of two coronavirus vaccines as well as administration codes unique to each such vaccine and dose. The new CPT codes clinically distinguish each COVID-19 vaccine for better tracking, reporting and analysis that supports data-driven planning and allocation. In addition, Appendix Q was created to facilitate an easy guide for proper reporting of all SARS-CoV-2 vaccine CPT codes.

In December 2020, the RUC convened a special meeting to review these four SARS-CoV-2 immunization administration codes. The specialty societies provided background on the previous valuation of CPT code 90470 *H1N1 immunization administration (intramuscular, intranasal), including counseling when performed.*

During the October 2009 meeting, the RUC provided recommendations for CPT code 90640 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* (work RVU = 0.20 and 7 minutes intra-service time) and direct practice expense (PE) inputs. During the same meeting, the RUC reviewed recommendations for CPT code 90470 *H1N1 immunization administration (intramuscular, intranasal), including counseling when performed*, which was fast-tracked to address the immediate need to vaccinate against the 2009 pandemic.

In 2009, at the request of the Department of Health and Human Services, the CPT Editorial Panel created new CPT code 90470 to assist the public health effort to immediately vaccinate for H1N1. CMS requested that the RUC immediately review the new service and provide recommendations on the estimated physician work and direct practice expense inputs necessary to provide the immunization. The RUC recommended the same work RVU of 0.20 and 7 minutes of intra-service time for H1N1 code 90470 as it did for CPT code 90460. Additionally, the RUC recommended the direct PE inputs for CPT code 90470 be equivalent to CPT code 90460 with two primary exceptions. First, an additional two minutes of staff time were added to capture the additional work of identifying and contacting patients as the vaccine is provided by the state. In addition, the standard greet patient time of 3 minutes was added since an evaluation and management code is not additionally reported as part of the typical patient encounter for vaccinating during a pandemic.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CMS accepted the RUC recommendations for CPT code 90470, publishing a work RVU 0.20 and PE RVU of 0.42 on the 2010 Medicare Physician Payment Schedule (MFS), representing the resources utilized in vaccinating the public during a pandemic.

However, CMS crosswalked CPT code 90460 to CPT code 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid*) (work RVU = 0.17), which, in turn, was hard coded to CPT code 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular* (work RVU = 0.17). CPT code 90470 was sunset at the end of the H1N1 pandemic.

In the Proposed Rule for 2021, CMS noted that the IA payment rates resulting from the CPT code 96372 hard coding were substantially lower than the Centers for Disease Control and Prevention (CDC) regional maximum charges. CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services, as it is critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks.

SARS-CoV-2 (COVID-19) Immunization Administration

The RUC reviewed the specialty society recommendation and agreed that 0001A, 0002A, 0011A and 0012A should be crosswalked to the 2009 RUC recommendation for CPT code 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* (2009 recommended work RVU = 0.20 and 7 minutes of intra-service time).

For additional support the RUC referenced codes 96411 *Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)* (work RVU = 0.20 and 7 minutes total time), 99188 *Application of topical fluoride varnish by a physician or other qualified health care professional* (work RVU = 0.20 and 9 minutes total time) and 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21 and 9 minutes total time).

In the case of the COVID-19 vaccine requiring two doses, the total physician work resources required for the first dose should be equivalent to those required for the second dose to account for the possibility that a patient may not return to the same physician or even the same physician group for the second dose administration. Valuation must account for any necessary physician work to confirm the details of a patient's first dose. The specialty societies indicated, and the RUC agreed that the first and second dose both require 7 minutes of physician time. Data from the Phase III clinical trials involving these two mRNA COVID-19 vaccines indicate that patients receiving the second dose are more likely to experience adverse effects and the physician involvement addressing such questions are the same for both doses. The RUC agreed that there is no difference in physician work between the administration of the first and second dose, nor is there any difference in physician work or time to administer the Pfizer-BioNTech and Moderna immunizations. Therefore, the RUC recommends all four COVID-19 IA codes be crosswalked from the 2009 RUC recommendations for CPT code 90460 with respect to work and intra-service time. **The RUC recommends a work RVU of 0.20 and intra-service time of 7 minutes for CPT codes 0001A, 0002A, 0011A and 0012A.**

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Practice Expense
The Practice Expense (PE) Subcommittee thoroughly and extensively discussed the practice expense inputs involved with the SARS-CoV-2 immunization administration codes in the physician office setting. The Subcommittee compared the direct PE inputs for the new IA codes with reference code 90460 and former CPT code 90470 and determined that the clinical staff times approved for code 90470 during the 2009 pandemic were appropriate. The inputs were modified to mirror the clinical staff times that had been in place for CPT code 90470. The Subcommittee also determined that new CPT code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease* would be utilized with these codes and thus removed the clinical staff times that would overlap with those in 99072. **The RUC strongly recommends that CMS approve payment for CPT code 99072 during the PHE.**

The specialty societies emphasized that though the clinical staff activities may be similar to other vaccination codes, the typical amount of clinical staff time is higher due to the requirements inherent in a public health emergency. There was significant discussion regarding the considerable documentation requirements that accompany these immunization administration codes. There was agreement that 2 minutes was appropriate for the first dose of both vaccines to identify and contact appropriate patients and schedule immunization. Concern was expressed, however, that the RN/LPN/MTA blend was not appropriate for registry entry, thus the staff labor type was modified for CA033 *Perform regulatory mandated quality assurance activity (service period)* to L026A *Medical/Technical Assistant*. A lesser amount of clinical staff time was allotted for CA034 *Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)* with L037D *RN/LPN/MTA,* recognizing that more than baseline medical knowledge is required for this activity. There was also recognition that the initial data entry would require more time and the minutes for CA033 and CA034 in the subsequent codes were reduced accordingly. The CDC recommends 15 minutes of monitoring the patient following the administration of each dose for both vaccines. The PE Subcommittee agreed that the standard of 1 minute of clinical staff time to every 4 minutes of patient monitoring is appropriate, leading to 4 minutes of clinical staff monitoring time. A follow-up phone call from the patient to the practice to discuss symptoms or address questions was accepted as typical.

The PE Subcommittee also extensively discussed the supply and equipment inputs associated with the immunization administration codes. Supplies were modified to increase SB022 *gloves, non-sterile* to reflect a full pair and to remove the COVID-19 cleaning supplies including additional quantities of hand sanitizer and disinfecting wipes/sprays/cleansers as these are included in CPT code 99072. The PE Subcommittee excluded any supplies that are included in the ancillary supply kit supplied by the Federal Government at no cost to enrolled COVID-19 vaccine providers.

The equipment discussion focused on the definition and utilization of refrigeration, cooling devices and alarm systems. The utilization of two new additional pieces of equipment *(refrigerator, vaccine medical grade, w-data logger sngl glass door* and *freezer, under counter, ultra-cold 3.7 cu ft.)* were proposed and accepted. In 2019, there was significant discussion about the existing equipment ED043 *refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates* and whether it was a direct or indirect expense. At that time, ED043 was retained as a direct expense in accordance with the spreadsheet. The medication-grade refrigerator is used solely to store highly expensive and fragile biologics for use at the time they are needed. Although the medications are stored for longer than the length of the service, it would be extremely difficult to determine typical length of storage as this varies across local sites. The RUC and CMS have a precedent of including refrigerators in

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

direct expense costs and using the total clinical staff time for the equipment minutes, as was done for vaccination codes, including codes 90471, 90472, 90473, and 90474, where the equipment time for the refrigerator is equal to the total clinical staff time. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Preventive Medicine Services** *The following codes are used to report . . .* . . . Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (eg, vision, hearing, developmental) identified with a specific CPT code are reported separately. For immunization administration and vaccine risk/benefit counseling, see 90460, 90461, 90471-90474, 0001A, 0002A, 0011A, 0012A. For vaccine/toxoid products, see 90476-90749, 91300, 91301. **Medicine** 91300 Codes are out of numerical sequence. See 90472-90581 91301 Codes are out of numerical sequence. See 90472-90581 **Immunization Administration for Vaccines/Toxoids** Report vaccine immunization administration codes (90460, 90461, 90471-90474, 0001A, 0002A, 0011A, 0012A) in addition to the vaccine and toxoid code(s) (90476-90749, 91300, 91301). Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient/family during the administration of a vaccine other than when performed for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccines. For immunization administration of any vaccine, other than SARS-CoV-2 (Coronavirus disease [COVID-19]) vaccines, that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family/guardian or for administration of vaccines to patients over 18 years of age, report 90471-90474. (See also **Instructions for Use of the CPT Codebook** for definition of reporting qualifications.) Report 0001A, 0002A, 0011A, 0012A for immunization administration of SARS-CoV-2 (Coronavirus disease [COVID-19]) vaccines only. Each administration code is specific to each individual vaccine product (eg, 91300, 91301), the dosage schedule (eg, first dose, second dose), and counseling, when performed. The appropriate administration code is chosen based on the type of vaccine and the specific dose number the patient receives in the				

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

schedule. For example, 0012A is reported for the second dose of vaccine 91301. Do not report 90460-90474 for the administration of SARS-CoV-2 (Coronavirus disease [COVID-19]) vaccines. Codes related to SARS-CoV-2 (Coronavirus disease [COVID-19]) vaccine administration are listed in Appendix Q, with their associated vaccine code descriptors, vaccine administration codes, vaccine manufacturer, vaccine name(s), National Drug Code (NDC) Labeler Product ID, and interval between doses. In order to report these codes, the vaccine must fulfill the code descriptor and must be the vaccine represented by the manufacturer and vaccine name listed in Appendix Q.

If a significant separately identifiable Evaluation and Management service (eg, new or established patient office or other outpatient services [99202-99215], office or other outpatient consultations [99241-99245],emergency department services [99281-99285], preventive medicine services [99381-99429]) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes.

A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism (90460 and 90461). Multi-valent antigens or multiple serotypes of antigens against a single organism are considered a single component of vaccines. Combination vaccines are those vaccines that contain multiple vaccine components. Conjugates or adjuvants contained in vaccines are not considered to be component parts of the vaccine as defined above.

(For allergy testing, see 95004 et seq)

(For skin testing of bacterial, viral, fungal extracts, see 86485-86580)

(For therapeutic or diagnostic injections, see 96372-96379)

90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered*

+90461 *each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)*

(Use 90460 for each vaccine administered. For vaccines with multiple components [combination vaccines], report 90460 in conjunction with 90461 for each additional component in a given vaccine)

(Do not report 90460, 90461 in conjunction with 91300, 91301, unless both a severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease {COVID-19}] vaccine/toxoid product and at least one vaccine/toxoid product from 90476-90749 are administered at the same encounter)

90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*

(Do not report 90471 in conjunction with 90473)

+90472 *each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)*

(Use 90472 in conjunction with 90460, 90471, 90473)

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

(Do not report 90471, 90472 in conjunction with 91300, 91301, unless both a severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease {COVID-19}] vaccine /toxoid product and at least one vaccine/toxoid product from 90476-90749 are administered at the same encounter)

(For immune globulins, see 90281-90399. For administration of immune globulins, see 96365, 96366, 96367, 96368, 96369, 96370, 96371, 96374)

(For intravesical administration of BCG vaccine, see 51720, 90586)

90473 *Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)*

(Do not report 90473 in conjunction with 90471)

+90474 *each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)*

(Use 90474 in conjunction with 90460, 90471, 90473)

(Do not report 90473, 90474 in conjunction with 91300, 91301, unless both a severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [Coronavirus disease {COVID-19}] vaccine/toxoid product and at least one vaccine/toxoid product from 90476-90749 are administered at the same encounter)

●0001A	A1	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	XXX	0.20
●0002A	A2	second dose (Report 0001A, 0002A for the administration of vaccine 91300)	XXX	0.20
●0011A	A3	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	XXX	0.20
●0012A	A4	second dose (Report 0011A, 0012A for the administration of vaccine 91301)	XXX	0.20

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

December 9, 2020

Peter Smith, MD
Chairperson, AMA/Specialty Society Relative Value Scale Update Committee
Relative Value Systems, American Medical Association
330 N Wabash Ave, Suite 39300
Chicago, IL 60611

Re: COVID-19 Immunization Administration Codes (0001A, 0002A, 0011A, 0012A)

Dear Doctor Smith:

The American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), and American Academy of Pediatrics (AAP) respectfully submit recommendations for the COVID-19 Immunization Administration codes as follows:

0001A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose
Recommendation:
•Crosswalk to October 2009 RUC-recommended work relative value units (RVUs) and intraservice time (7 minutes) for CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered)
•Utilize October 2009 RUC-recommended direct practice expense inputs for CPT code 90460 as a template with incremental direct practice expense inputs required for administering the COVID-19 vaccine

0002A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose
Recommendation:
•Crosswalk to October 2009 RUC-recommended work relative value units (RVUs) and intraservice time (7 minutes) for CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered)
•Utilize October 2009 RUC-recommended direct practice expense inputs for CPT code 90460 as a template with incremental direct practice expense inputs required for administering the COVID-19 vaccine

0011A Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose
Recommendation:
•Crosswalk to October 2009 RUC-recommended work relative value units (RVUs) and intraservice time (7 minutes) for CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered)

•Utilize October 2009 RUC-recommended direct practice expense inputs for CPT code 90460 as a template with incremental direct practice expense inputs required for administering the COVID-19 vaccine

0012A Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose

Recommendation:

•Crosswalk to October 2009 RUC-recommended work relative value units (RVUs) and intraservice time (7 minutes) for CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered)

•Utilize October 2009 RUC-recommended direct practice expense inputs for CPT code 90460 as a template with incremental direct practice expense inputs required for administering the COVID-19 vaccine

Research Subcommittee Approval

The Research Subcommittee approved our request to submit COVID-19 immunization administration (IA) recommendations using a crosswalk methodology:

- *The Research Subcommittee approves for the use of a crosswalk methodology in general to value (0001A, 0002A, 0011A, 0012A). A couple of members expressed concern that future Covid-19 immunization administration codes may present unforeseen costs and questioned whether there should be a blanket recommendation about future codes. The Subcommittee notes it is the purview of the RUC to determine the specific crosswalk code.*

Background

During the October 2009 meeting, the RUC approved 0.20 wRVU, 7 minutes intraservice time, and direct practice expense (PE) inputs for CPT code 90460. During the same meeting, the RUC reviewed recommendations for CPT code 90470 (H1N1 immunization administration (intramuscular, intranasal), including counseling when performed) which was fast tracked to address the immediate need to vaccinate against the 2009 pandemic.

At the request of the Department of Health and Human Services, the CPT Editorial Panel created new CPT code 90470 to assist the public health effort to immediately vaccinate for H1N1. CMS asked the RUC to immediately review the new service and provide recommendations on the estimated physician work and direct practice expense inputs anticipated to be required to provide the immunization. The RUC recommended the same wRVU (0.20) and intraservice time (7 minutes) for 90470 as it did for CPT code 90460. Additionally, the RUC recommended the direct PE inputs for CPT code 90470 be equivalent to CPT code 90460 with two primary exceptions. First, an additional two minutes of staff time was added to capture the additional work of identifying and contacting patients as the vaccine is provided by the state. In addition, the standard greet patient time of 3 minutes was added since an evaluation and management code is not additionally reported as part of the typical patient encounter for vaccinating during a pandemic.

CMS accepted the RUC recommendations for CPT code 90470, publishing 0.20 wRVU and 0.42 PE RVUs on the 2010 Medicare Physician Fee Schedule (MPFS), representing the resources utilized in vaccinating the public during a pandemic.

CPT code 90460, however, was crosswalked by CMS to CPT code 90471 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or

combination vaccine/toxoid), which, in turn, was hard coded to CPT code 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular).

In the 2021 MPFS proposed rule, CMS noted that the IA payment rates resulting from the 96372 hard coding were substantially lower than the Centers for Disease Control and Prevention (CDC) regional maximum charges. CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services, as it is critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. (Source: CMS 1734-P (page 268))

With the exception of CPT code 90470, CMS has never accepted RUC survey-based recommendations for IA codes. This holds true even though the RUC recommendations for CPT code 90460 formed the basis of CMS' valuation of CPT code 90470. CPT code 90470 was sunset at the end of the pandemic.

Rationale

1) The October 2009 RUC-recommended wRVU and intraservice time for CPT code 90460 are the appropriate crosswalks for the COVID IA codes. The October 2009 RUC-recommended direct PE inputs for CPT code 90460 form the appropriate template for the COVID IA codes.

2) As resource expenditure is equivalent among all four COVID-19 IA codes, there should be no payment differential between the first dose administration and second/subsequent dose administration in a multidose COVID-19 vaccine schedule.

	First Dose Administration	Second/Subsequent Dose Administration	Equivalent?
Work (ie, Counseling)	•Vaccine hesitancy (rising rates in general population coupled with trend toward lack of trust in CDC/public health) •Enhanced consent required to administer new vaccine in unlicensed patient population (eg, pediatric patients)	•Ongoing or new vaccine hesitancy •Patient questions on ability to intermix vaccine products; uncertain patient vaccine history; patient confusion about minimum interval requirement for receiving second/subsequent dose; side effects from first/prior dose	Yes
Administrative Staff Time (Indirect PE)	•Schedule follow-up appointment for next dose compliant with the vaccine's minimum interval requirement	•Patient reminder/recall to comply with 21/28-day minimum interval requirement •Schedule follow-up appointment for next dose compliant with the vaccine's minimum interval requirement	Yes

Clinical Staff Time Clinical Staff Time (continued)	•Identify and contact appropriate patients and schedule immunization •Prepare patient chart with appropriate CDC vaccine information sheet (VIS) •Inventory vaccines specific to limited distribution of COVID vaccine (ie, account for every dose given, wastage and spoilage reports) •Greet patient, provide gowning, ensure appropriate medical records •Provide pre-service education (eg, what to expect, what to do afterwards, signs/symptoms that merit a call to the office) and obtain consent •Provide patient/parent with appropriate CDC VIS •Obtain vital signs •Prepare room/equipment/supplies •Administer vaccine •Clean room/equipment •Check on patient before discharge and answer final questions •Provide required paper form to patient •Enter vaccine information into the patient medical record •Conduct expanded immunization information system (IIS) reporting •Maintain vaccine refrigerator/freezer temperature log	•Identify and contact appropriate patients and schedule immunization •Prepare patient chart with appropriate CDC VIS •Inventory vaccines specific to limited distribution of COVID vaccine (ie, account for every dose given, wastage and spoilage reports) •Greet patient, provide gowning, ensure appropriate medical records •Provide pre-service education (eg, what to expect, what to do afterwards, signs/symptoms that merit a call to the office) and obtain consent •Confirm appropriate interval from prior dose •Provide patient/parent with appropriate CDC VIS •Obtain vital signs •Prepare room/equipment/supplies •Administer vaccine •Clean room/equipment •Check on patient before discharge and answer final questions •Provide required paper form to patient •Enter vaccine information into the patient medical record •Conduct expanded IIS reporting •Maintain vaccine refrigerator/freezer temperature log	Yes Expanded IIS reporting: Please see example of Texas' expanded IIS reporting
Medical Supplies	•Gloves •OSHA compliant syringe w-needle	•Gloves •OSHA compliant syringe w-needle	Yes

	•Alcohol swab •Bandage •CDC VIS •PPE (CPT code 99072)	•Alcohol swab •Bandage •CDC VIS •PPE (CPT code 99072)	
Medical Equipment	•Refrigerator, vaccine medical grade, w-data logger •Refrigerator, vaccine, temperature monitor w/alarm •Freezer, under counter, ultra cold 3.7 cu ft (0001A only)	•Refrigerator, vaccine medical grade, w-data logger •Refrigerator, vaccine, temperature monitor w/alarm •Freezer, under counter, ultra cold 3.7 cu ft (0002A only)	Yes
PLI			Yes

Additionally, in the case of the COVID-19 vaccine requiring two doses, the total resources required for the first dose should be at least equivalent to those required for the second dose to account for the possibility a patient may not return to the same physician or even same physician group for the second dose administration. Valuation must account for any necessary physician work to confirm the details of a patient's first dose.

Therefore, we believe all four COVID-19 IA codes listed above should be crosswalked from the RUC recommendations for CPT code 90460 with respect to work and intraservice time. Additionally, the RUC-recommended direct PE inputs for code 90460 should be utilized as the template for the COVID IA codes, adding the incremental direct practice expense inputs required for administering the COVID-19 vaccine.

Sincerely,

Megan Adamson, MD, MHS-CL
RUC Advisor
American Academy of Family Physicians

Jon Hathaway, MD, PhD
RUC Advisor
American College of Obstetricians and Gynecologists

Tanvir Hussain, MD
RUC Advisor
American College of Physicians

Steven Krug, MD
RUC Advisor
American Academy of Pediatrics

Attachments:
October 2009 RUC Recommendations for Immunization Administration 90460-90461
October 2009 RUC Recommendations for H1N1 Immunization Administration 90470

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:0001A Tracking Number Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.20**

CPT Descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified health care professional reviews the patient's chart to confirm that vaccination to decrease the risk of COVID-19 is indicated. The patient is counseled on the benefits and risks of vaccination to decrease the risk of COVID-19 and consent is obtained. The first dose of the COVID-19 vaccine is administered by intramuscular injection in the upper arm. The patient is monitored for any adverse reaction. The patient's immunization record (and registry when applicable) are updated to reflect the vaccine administered.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	12/2020					
Presenter(s):	Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD					
Specialty Society(ies):	AAFP, ACOG, ACP, AAP					
CPT Code:	0001A					
Sample Size:	**Resp N:** 0					
Description of Sample:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate						
Survey RVW:						
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:			**0.00**			
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	0001A	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90460	XXX	0.20	**RUC Time**

CPT Descriptor Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source

CPT Descriptor

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99406	XXX	0.24	**RUC Time**	532,709

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92081	XXX	0.30	**RUC Time**	92,708

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Other Reference CPT Code	Global	Work RVU	Time Source
90470	XXX	0.20	**RUC Time**

CPT Descriptor H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [SUNSET]

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 **% of respondents:** 0.0 **%**

Number of respondents who choose 2nd Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 0001A	**Top Key Reference CPT Code:** 90460	**2nd Key Reference CPT Code:** ____
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	7.00	7.00	7.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**7.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In response to the COVID-19 pandemic and public health need for rapid deployment of COVID-19 vaccines, RUC was asked to provide resource-based information for immunization administration (IA) for the administration codes specific to these vaccines. This occurred in the same time period that CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services in general, as critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. Prior to this point, CMS has not accepted RUC survey-based

recommendations for IA codes with the one exception of the value for CPT code 90470 -- immunization administration for the pandemic H1N1 vaccine in 2009. The value for CPT code 90470 was a crosswalk to the RUC-approved value for CPT code 90460 at the same RUC meeting because the timing of the H1N1 vaccine need did not allow for a separate survey. The CPT code 90470 was viewed as temporary for the pandemic; however, the source for the CPT code 90470 wRVU remains in the RUC database for CPT code 90460. This expert panel therefore believes that the physician work for the COVID IA is the same as the RUC recommended work for CPT code 90460 (and CPT code 90470).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A; this is a new service

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90460

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:0002A Tracking Number Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.20**

CPT Descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified health care professional reviews the patient's chart to confirm that vaccination to decrease the risk of COVID-19 is indicated. The patient is counseled on the benefits and risks of vaccination to decrease the risk of COVID-19 and consent is obtained. The first dose of the COVID-19 vaccine is administered by intramuscular injection in the upper arm. The patient is monitored for any adverse reaction. The patient's immunization record (and registry when applicable) are updated to reflect the vaccine administered.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	12/2020					
Presenter(s):	Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD					
Specialty Society(ies):	AAFP, ACOG, ACP, AAP					
CPT Code:	0002A					
Sample Size:	**Resp N:** 0					
Description of Sample:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate						
Survey RVW:						
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:			**0.00**			
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	0002A	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90460	XXX	0.20	**RUC Time**

CPT Descriptor Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source

CPT Descriptor

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99406	XXX	0.24	**RUC Time**	532,709

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92081	XXX	0.30	**RUC Time**	92,708

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Other Reference CPT Code	Global	Work RVU	Time Source
90470	XXX	0.20	**RUC Time**

CPT Descriptor H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [SUNSET]

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 **% of respondents:** 0.0 **%**

Number of respondents who choose 2nd Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 0002A	**Top Key Reference CPT Code:** 90460	**2nd Key Reference CPT Code:** _____
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	7.00	7.00	7.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**7.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In response to the COVID-19 pandemic and public health need for rapid deployment of COVID-19 vaccines, RUC was asked to provide resource-based information for immunization administration (IA) for the administration codes specific to these vaccines. This occurred in the same time period that CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services in general, as critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. Prior to this point, CMS has not accepted RUC survey-based

recommendations for IA codes with the one exception of the value for CPT code 90470 -- immunization administration for the pandemic H1N1 vaccine in 2009. The value for CPT code 90470 was a crosswalk to the RUC-approved value for CPT code 90460 at the same RUC meeting because the timing of the H1N1 vaccine need did not allow for a separate survey. The CPT code 90470 was viewed as temporary for the pandemic; however, the source for the CPT code 90470 wRVU remains in the RUC database for CPT code 90460. This expert panel therefore believes that the physician work for the COVID IA is the same as the RUC recommended work for CPT code 90460 (and CPT code 90470).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A; this is a new service

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90460

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:0011A Tracking Number Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.20**

CPT Descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified health care professional reviews the patient's chart to confirm that vaccination to decrease the risk of COVID-19 is indicated. The patient is counseled on the benefits and risks of vaccination to decrease the risk of COVID-19 and consent is obtained. The first dose of the COVID-19 vaccine is administered by intramuscular injection in the upper arm. The patient is monitored for any adverse reaction. The patient's immunization record (and registry when applicable) are updated to reflect the vaccine administered.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	12/2020					
Presenter(s):	Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD					
Specialty Society(ies):	AAFP, ACOG, ACP, AAP					
CPT Code:	0011A					
Sample Size:	0	**Resp N:**	0			
Description of Sample:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate						
Survey RVW:						
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:			**0.00**			
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	0011A	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90460	XXX	0.20	**RUC Time**

CPT Descriptor Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source

CPT Descriptor

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99406	XXX	0.24	**RUC Time**	532,709

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92081	XXX	0.30	**RUC Time**	92,708

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Other Reference CPT Code	Global	Work RVU	Time Source
90470	XXX	0.20	**RUC Time**

CPT Descriptor H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [SUNSET]

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 **% of respondents:** 0.0 **%**

Number of respondents who choose 2nd Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 0011A	**Top Key Reference CPT Code:** 90460	**2nd Key Reference CPT Code:** ____
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	7.00	7.00	7.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**7.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In response to the COVID-19 pandemic and public health need for rapid deployment of COVID-19 vaccines, RUC was asked to provide resource-based information for immunization administration (IA) for the administration codes specific to these vaccines. This occurred in the same time period that CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services in general, as critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. Prior to this point, CMS has not accepted RUC survey-based

recommendations for IA codes with the one exception of the value for CPT code 90470 -- immunization administration for the pandemic H1N1 vaccine in 2009. The value for CPT code 90470 was a crosswalk to the RUC-approved value for CPT code 90460 at the same RUC meeting because the timing of the H1N1 vaccine need did not allow for a separate survey. The CPT code 90470 was viewed as temporary for the pandemic; however, the source for the CPT code 90470 wRVU remains in the RUC database for CPT code 90460. This expert panel therefore believes that the physician work for the COVID IA is the same as the RUC recommended work for CPT code 90460 (and CPT code 90470).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A; this is a new service

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90460

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:0012A Tracking Number Original Specialty Recommended RVU: **0.20**
Presented Recommended RVU: **0.20**
Global Period: XXX Current Work RVU: RUC Recommended RVU: **0.20**

CPT Descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The physician or other qualified health care professional reviews the patient's chart to confirm that vaccination to decrease the risk of COVID-19 is indicated. The patient is counseled on the benefits and risks of vaccination to decrease the risk of COVID-19 and consent is obtained. The first dose of the COVID-19 vaccine is administered by intramuscular injection in the upper arm. The patient is monitored for any adverse reaction. The patient's immunization record (and registry when applicable) are updated to reflect the vaccine administered.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	12/2020					
Presenter(s):	Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD					
Specialty Society(ies):	AAFP, ACOG, ACP, AAP					
CPT Code:	0012A					
Sample Size:	**Resp N:** 0					
Description of Sample:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate						
Survey RVW:						
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:			**0.00**			
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	0012A	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
90460	XXX	0.20	**RUC Time**

CPT Descriptor Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source

CPT Descriptor

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99406	XXX	0.24	**RUC Time**	532,709

CPT Descriptor 1 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92081	XXX	0.30	**RUC Time**	92,708

CPT Descriptor 2 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Other Reference CPT Code	Global	Work RVU	Time Source
90470	XXX	0.20	**RUC Time**

CPT Descriptor H1N1 immunization administration (intramuscular, intranasal), including counseling when performed [SUNSET]

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 **% of respondents:** 0.0 **%**

Number of respondents who choose 2nd Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 0012A	**Top Key Reference CPT Code:** 90460	**2nd Key Reference CPT Code:** ____
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	7.00	7.00	7.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**7.00**	**7.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

2nd Key Reference Code

	Much Less	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity					

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making			

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required			
Physical effort required			

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In response to the COVID-19 pandemic and public health need for rapid deployment of COVID-19 vaccines, RUC was asked to provide resource-based information for immunization administration (IA) for the administration codes specific to these vaccines. This occurred in the same time period that CMS agreed with the RUC regarding the importance of appropriate resource-based valuation for IA services in general, as critical in maintaining high immunization rates in the United States, as well as ensuring capacity to respond quickly to vaccinate against preventable disease outbreaks. Prior to this point, CMS has not accepted RUC survey-based

recommendations for IA codes with the one exception of the value for CPT code 90470 -- immunization administration for the pandemic H1N1 vaccine in 2009. The value for CPT code 90470 was a crosswalk to the RUC-approved value for CPT code 90460 at the same RUC meeting because the timing of the H1N1 vaccine need did not allow for a separate survey. The CPT code 90470 was viewed as temporary for the pandemic; however, the source for the CPT code 90470 wRVU remains in the RUC database for CPT code 90460. This expert panel therefore believes that the physician work for the COVID IA is the same as the RUC recommended work for CPT code 90460 (and CPT code 90470).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) N/A; this is a new service

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency <u>and percentage</u> for each specialty. Please explain the rationale for this estimate.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Other

BETOS Sub-classification:
Immunizations/Vaccinations

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 90460

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.

Hide columns and rows that do not contain data.

1st REF = Top Key Reference code data

2st REF = Second Highest Key Reference code data

CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.

SVY = Survey data - as it appears on the Summary of Recommendation form.

REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: COVID Immunization Administration

TAB:

								RVW					Total	PRE-TIME			INTRA-TIME					IMMD
Source	CPT	Global	DESC	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
1st REF RUC REC 2009	90460	XXX	Immunization administration through 18 years of age via any		0.029	0.029			0.20			7						7			
2021 CMS	90460	XXX	Immunization administration through 18 years of age via any		0.024	0.024			0.17			7						7			
	96411	ZZZ	Chemotherapy administration; intravenous, push technique,		0.033	0.029			0.20			7	3					4			
	99188	XXX	Application of topical fluoride varnish by a physician or other		0.022	0.022			0.20			9	2					5			2
	96365	XXX	Intravenous infusion, for therapy, prophylaxis, or		0.024	0.023			0.21			9	2					5			2
REC	0001A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			
REC	0002A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			
REC	0011A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			
REC	0012A	XXX	Immunization administration by intramuscular injection of		0.029	0.029			0.20			7						7			

NONFACILITY DIRECT PE INPUTS

CPT CODE(S):0001A-0002A & 0011A-0012A
SPECIALTY SOCIETY(IES): AAFP, ACOG, ACP, AAP
PRESENTER(S): Megan Adamson, MD; Jon Hathaway, MD; Tanvir Hussain, MD; Suzanne Berman, MD; Steven Krug, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: December 2020

CPT Code	Long Descriptor	Global Period
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	XXX
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose	XXX
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	XXX
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
0001A	A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.
0002A	A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.
0011A	A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.
0012A	A 33-year-old individual seeks immunization against SARS-CoV-2 to decrease the risk of contracting this disease consistent with evidence supported guidelines. The individual is offered and accepts an intramuscular injection of SARS-CoV-2 vaccine for this purpose.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   RUC Advisors from AAFP, ACOG, ACP, and AAP acted as an expert panel and met by video conferencing, phone, and email to develop the recommended direct PE inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Samantha Ashley at samantha.ashley@ama-assn.org for PE spreadsheets for your reference codes*):

   We are utilizing CPT code 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered) as our base reference code due to the inherent similarity between the service described by 90460 and the COVID Immunization Administration (IA) codes. To the base of 90460 direct PE inputs, we are recommending incremental direct PE inputs as required by public health emergency (PHE) regulations for administering the pandemic COVID-19 vaccine.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No and no. The typical patient will not be seen for an E/M service as the COVID-19 vaccine is being administered in response to its pandemic status.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   CPT code 90460: Family Medicine; 46%; no.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   CA033: The additional minutes (7 minutes for 0001A and 0011A; 5 minutes for 0002A and 0012A) reflect 1 minute for manually filling out the vaccine card required to be given to the patient plus another 6 minutes (for 0001A and 0011A) or 4 minutes (for 0002A and 0012A) of logging required information into the registry (eg, IIS, VAMS) and maintaining vaccine refrigerator/freezer temperature logs. The typical patient is an adult who will need new record creation in IIS for 0001A and 0011A, which typically takes 2 minutes to create and enter demographic information. New record creation will not be needed for the second dose given 21-28 days later (0002A and 0012A). Therefore, the 6 minutes for 0001A and 0011A reflects patient record creation and demographic entry (2 minutes) plus the actual vaccine information logging time and maintenance of vaccine refrigerator/freezer temperature logs (4 minutes). The 4 minutes for 0002A and 0012A reflects only

the actual vaccine information logging time and maintenance of vaccine refrigerator/freezer temperature logs (4 minutes).
CA034: The individual (RN/LPN/MTA) who performs the actual vaccine administration must be the person who documents the procedure in the patient's medical record (ie, "the person who did it documents it, and the person who documented it did it"). The 3 minutes is the same for both dose one (0001A and 0011A) and dose two (0002A and 0012A).

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

As a result of the COVID-19 pandemic and vaccine emergency use authorization (EUA) status, administration of the COVID-19 vaccine has direct PE inputs over and above those required for "regular" immunization administration, which cannot be entirely accounted for due to an increase in physician time:

- Vaccine inventory specific to limited distribution of COVID vaccine (ie, account for every dose given, wastage and spoilage reports) (1 minute to CA008)
- Identify and contact appropriate patients and schedule immunization (2 minutes for 0001A and 0011A only) (originally assigned to Row 26 NEW but subsequently moved to CA005)
- Due to risk of anaphylaxis with COVID-19 vaccine, post-procedure monitoring multitasking 1:4 (4 minutes to CA022)
- Providing patient with paper vaccine card (1 minute to CA033)
- Enter additional data into immunization information system (IIS) as required by state and federal regulations (6 minutes for 0001A and 0011A and 4 minutes for 0002A and 0012A to CA033)
- Use of an ultra cold freezer for storing vaccine (NEW, line 113) (93% of IS CST for 0001A-0002A (only))
- Use of a medical grade vaccine refrigerator (NEW, line 112) (100% of IS CST for 0011A-00012A; 7% of IS CST for 0001A-0002A)
- Each refrigerator requires a temperature monitor with alarm (ED043), which is accounted for in the total minutes for combined use of ultra cold freezer and medical grade vaccine refrigerator (eg, Row 108: 37 minutes =3 minutes +34 minutes for 0001A)

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Prepare patient chart with appropriate CDC VIS: Rolled into CA001
Provide patient/parent with appropriate CDC VIS: Rolled into CA012
Clinical staff (RN/LPN/MTA) enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.: Rolled into CA034
Clinical staff (Medical/Technical Assistant) enters data into the state online immunization information system (IIS) (registry) and maintains the vaccine refrigerator/freezer temperature logs.: Rolled into CA033

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

We allocated 0 minutes to obtain vital signs and, therefore, are requesting no CST.

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Complete pre-service diagnostic and referral forms (ie, prepare patient chart with appropriate CDC VIS); Complete pre-procedure phone calls and prescription (ie, identify and contact appropriate patients and schedule immunization (0001A and 0011A only)); Perform regulatory mandated quality assurance activity (ie, vaccine inventory specific to limited distribution of COVID vaccine (ie, account for every dose given, wastage and spoilage reports).

   b. Service period (includes pre, intra and post):

Greet patient, provide gowning, ensure appropriate medical records; Provide education and obtain consent; Review requisition, assess for special needs (ie, provide patient/parent with appropriate CDC VIS); Prepare room, equipment, and supplies; Monitor patient following procedure; Clean room/equipment; Enter vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law; Enter additional data as required by state and federal regulations into the state online immunization information system (IIS) (registry); Maintain the vaccine refrigerator/freezer temperature log; Provide required paper card and information sheet to patient.

   c. Post-service period:

Conduct patient communication.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

RN/LPN/MTA prepares the vaccine, instructs the patient (or parent) on proper positioning, selects and prepares the injection site, administers the vaccine, and applies a bandage to the injection site. The patient is then monitored for potential anaphylaxis response to the vaccine.

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

While *identify and contact appropriate patients and schedule immunization* was originally assigned to Row 26 NEW, it was subsequently moved to CA005. This is required by the CDC and local public health as the COVID-19 vaccine will be delivered in tiers (2 minutes for 0001A and 0011A only).

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

18. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

McKesson redacted invoice attached, includes estimates for refrigerator, vaccine medical grade, w-data logger sngl glass door ($7,674.43) and freezer, under counter, ultra cold 3.7 cu ft ($16,516.36). Please note that the latter is only applied to CPT codes 0001A-0002A.

19. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet workbook*):

10 years

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Formula: Default Refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates (SD043) Refrigerator, vaccine medical grade, w-data logger sngl glass door (NEW) ($7,674.43) Freezer, under counter, ultra cold 3.7 cu ft (NEW) ($16,516.36) (0001A and 0002A only)

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the PE spreadsheet and summary of recommendation (PE SOR) documents based on modifications made during the meeting. Please submit the revised documents electronically to Samantha Ashley at samantha.ashley@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

Removed 3 minutes for CA005 *Complete pre-procedure phone calls and prescription* Removed 2 minutes for NEW *Identify and contact appropriate patients and schedule immunization* for codes 0002A and 0012A only Moved *Identify and contact appropriate patients and schedule immunization* (2 minutes for 0001A and 0011A only) originally assigned to Row 26 NEW to CA005 Removed 1 minute for CA010 *Obtain vital signs* Added 4 minutes for CA022 *Post-procedure monitoring multitasking 1:4* Reduced from 5 minutes to 3 minutes CA024 *Clean room/equipment by clinical staff* Added 7 minutes (0001A and 0011A) and 5 minutes (0002A and 0012A) for CA033 *Perform regulatory mandated quality assurance activity* Changed staff type from L037D to L026D for CA033 *Perform regulatory mandated quality assurance activity* Added 3 minutes for *CA034 Document procedure (nonPACS) (eg, mandated reporting, registry logs, EEG file, etc.)*

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Removed 3 minutes for OLD *Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.*
Removed 4 minutes for OLD *Clinical staff enters data into the state online immunization information system (IIS) (registry) and maintains the vaccine refrigerator/freezer temperature log.*
CA037 *Conduct patient communications*: Removed 1 minute from all Facility settings; Added 2 minutes to all Non-Facility settings
Removed 3 SB033 *Mask, surgical*
Removed 1 SC058 *Syringe w-needle, OSHA compliant (SafetyGlide)*
Removed 1 SJ053 *Swab-pad, alcohol*
Increased SB022 *Gloves, non-sterile* from 0.5 to 1
Removed SK012 *CDC Information Sheet*
Added 1 SK057 *Paper, laser printing (each sheet)*
Removed 1 NEW *Covid-19 Cleaning Supplies including additional quantities of hand sanitizer and disinfecting wipes/sprays/cleansers*
Revised time for ED043 *Refrigerator, vaccine, temperature monitor w-alarm, security mounting w-sensors, NIST certificates* for total CST (ie, 37 for 0001A and 0011A and 33 for 0002A and 0012A)
Added NEW *Refrigerator, vaccine medical grade, w-data logger sngl glass door:* Assigned IS CST for 0011A (37) and 0012A (33); Assigned 7% of IS CST for 0001A (3) and 0002A (2)
Added NEW *Freezer, under counter, ultra cold 3.7 cu ft:* Assigned 93% of IS CST for 0001A (34) and 0002A (31) only
Please see below for 0001A-0002A refrigerator/freezer allocation calculation.

0001A-0002A Refrigerator/Freezer Allocation Calculation
Source:https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf (page 55)

If we are keeping vaccine in the ultra cold freezer, we can assume an average carrying time of 2 weeks (between receipt date and administration date). This is based around CDC expectation that only large sites that can give the vaccine quickly will get the vaccine (ie, 2x faster than normal carrying time of "standard vaccine," which is 3.5-4 weeks).

You may only use thawed vaccine (ie, not frozen but not yet diluted and kept in fridge) for 5 days. You may only use reconstituted vaccine (thawed and diluted and kept in fridge) for 6 hours.

Typically, only the last carrying day will be spent in the fridge (ie, you don't want to thaw it until you're pretty sure you can use it). So, even though it's acceptable to leave it in the fridge for up to 5 days, most won't try to do this because of the risk of ending up on day 6 with vaccine you don't need.

Therefore, for a total of 14 days carrying time:
13 days in ultra code freezer
1 day in refrigerator

Ultra cold freezer = 13/14 = 93% of total CST for 0001A and 0002A

Refrigerator = 1/14 = 7% of total CST for 0001A and 0002A

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2009

Immunization Administration

The CPT Editorial Panel revised the reporting of immunization administration in the pediatric population in order to better align the service with the evolving best practice model of delivering combination vaccines. This revision in the reporting of immunization administration will then permit a more accurate reflection of the physician work involved, reducing barriers to the spread of technology and allowing positive change in the practice of medicine. The CPT nomenclature needs to be kept up-to-date with the reporting of services associated with vaccine delivery, which has changed due to the licensure of additional combination vaccines as well as those with more components. The two new immunization administration codes will more accurately reflect the service as currently delivered.

The specialty society presented compelling evidence that the physician time has changed in performing these services by providing rationale for an increasing frequency of counseling necessary to convince parents to 1) immunize their children at all; and 2) to persuade them of the safety and efficacy of component vaccines. Increased attention to vaccine safety on the Internet and in other media has driven anxiety and have necessitated additional physician involvement and discussion with parents. The RUC agreed that this increased physician work should be recognized.

The specialty society presented that the typical patient receives two vaccinations in one visit. However, based upon the age of the patient and specific vaccines available, some visits require only 90460, some visits require one or more units of 90460 and one or more units of 90461. It was noted that higher multiples of reporting of these codes would occur at infrequent visits (primarily 2 month, 6 months, and 4 years of age) and any payor concern regarding coding and valuation with these outlier visits may be addressed with a limit on the number of 90461 units allowed.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

90460 Immunization Administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care profession; first vaccine/toxoid component

The RUC recommends that the survey intra-service time of 7 minutes should be reflected as the total time. Pre-service time, as described in the original SOR, is described in the preventive medicine services and the post-service descriptions reflect activities performed by clinical staff. The RUC agreed that the valuation for this service falls between the range of a 99211 (Work RVU=0.17) and the survey median of 0.25, and determined that considering that more than one unit is often coded, a value of 0.20 would be appropriate. 99401 *Preventive Counseling, 15 minutes* (work RVU = 0.48) is a reasonable comparison. Using the ratio of time of 7 minutes/15 minutes, a value of 0.20 is reasonable. In addition, the committee considered that they typical patient may receive two units of this service 0.40 total with 14 minutes of counseling, which is comparable to a 99212 (work RVU = 0.48 and 16 minutes of total time). **The RUC recommends a work value of 0.20 and physician intra-service time of 7 minutes for 90460.**

90461 – Immunization Administration through 18 years of age via any route of administration, with counseling by physician or other qualified health profession; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

The RUC understands that additional counseling is required to describe the additional vaccines and to address concern related to media reports of component vaccines. The survey indicated that this additional counseling requires 5 minutes of physician time. The RUC determined that the survey's 25th percentile work RVU of 0.16 is appropriate and reflects a proper rank order relationship with 99401 *Preventive Counseling* as described above and also in relationship to other counseling services, such as 99407 *Smoking Cessation (5/15 or 1/3 of 0.50).* **The RUC recommends a work value of 0.16 and a physician intra-service time of 5 minutes for 90461.**

Practice Expense – The RUC recommends the direct expense inputs of18 minutes clinical staff time, supplies and equipment for 90460 and no direct inputs for 90461 The individual inputs are described in the attached handout.

PLI Crosswalk – The new codes could be crosswalked to the existing immunization and administration codes, 90471 and 90472.

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Codes 90465-490460 and 90461 must be reported in addition to the vaccine and toxoid code(s) 90476-90749. Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471-90474. If a significant separately identifiable Evaluation and Management service (eg, office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes. A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism (see codes 90460 and 90461). Combination vaccines are those vaccines that contain multiple vaccine components. (For allergy testing, see 95004 et seq) (For skin testing of bacterial, viral, fungal extracts, see 86485-86580) (90465-90468 have been deleted. To report, see 90460, 90461)				
D 90465		~~Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day~~ ~~(Do not report 90465 in conjunction with 90467)~~	XXX	N/A
D +90466		~~Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; each additional injection (single or combination vaccine/toxoid), per day~~	ZZZ	N/A

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		~~(List separately in addition to code for primary procedure)~~ ~~(Use 90466 in conjunction with 90456 or 90467)~~		
D 90467		~~Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day~~ ~~(Do not report 90467 in conjunction with 90465)~~	XXX	N/A
D +90468		~~Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for~~ ~~(Use 90468 in conjunction with 90465 or 90467)~~	ZZZ	N/A
● 90460	E1	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component	XXX	0.20
● 90461	E2	each additional vaccine/toxoid component (List separately in addition to code for primary procedure) (Use 90460 for each vaccine administered. For vaccines with multiple components [combination vaccines], report 90460 in conjunction with 90461 for each additional component in a given vaccine) (For therapeutic or diagnostic injections, see 96372-96379) (90465-90468 have been deleted. To report, see 90460, 90461)	ZZZ	0.16

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90460 Tracking Number E1 Specialty Society Recommended RVU: **0.25**
Global Period: XXX RUC Recommended RVU: **0.20**

CPT Descriptor: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 15-year-old patient receives the Human Papilloma virus (HPV) vaccine from her physician. The ordering physician discusses the risks of the vaccine and the disease for which it provides protection. The parent/guardian is given the CDC vaccine information statement (VIS). The parent/guardian consents and the nurse prepares the vaccine. The patient receives the vaccine by a single injection, and the nurse charts the required information and accesses and enters the vaccine data into the statewide immunization registry. The patient is discharged home after the nurse confirms that there are no serious immediate reactions.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: The physician discusses the specific risks/benefits of the first vaccine component including the risks associated with this component and the risk of not receiving it to include both health risk from the preventable disease and the social concerns related to school mandates for vaccines. The physician then discusses the benefit of being immunized for this disease. The parent ‘s questions regarding the safety of the inactive ingredients in the vaccine such as preservatives and the likelihood of this vaccine causing injury, including brain damage, and/or the disease for which it is providing protection against are addressed. After further discussion, the parent then agrees with need for immunization. The physician then discusses the care plan for the child in the days to follow specific to the anticipated or possible side effects of the first vaccine component: soreness and pain at the injection site, fever, and other side effects. The physician reviews the signs or symptoms that warrant a call back.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009					
Presenter(s):	Steve Krug, MD, FAAP and Margie Andreae, MD, FAAP					
Specialty(s):	American Academy of Pediatrics (AAP)					
CPT Code:	90460					
Sample Size:	786	**Resp N:**	87	**Response:** 11.0 %		
Sample Type:	Panel **Additional Sample Information:** Sample drawn from membership of the AAP Section on Administration & Practice Management					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	250.00	**800.00**	1350.00	5000.00
Survey RVW:		0.15	0.25	**0.25**	0.39	0.75
Pre-Service Evaluation Time:				**3.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		0.00	5.00	**7.00**	8.00	20.00
Immediate Post Service-Time:	**2.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	90460	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		
Immediate Post Service-Time:	**0.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**		
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99441	XXX	0.25	**RUC Time**

CPT Descriptor Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,242,167

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	14

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
99406	XXX	0.24	**RUC Time**

CPT Descriptor Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39 **% of respondents:** 44.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 90460**	**Key Reference CPT Code:** 99441	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	7.00	8.00	
Median Immediate Post-service Time	0.00	4.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**7.00**	**13.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)		**(of those that selected Key Reference code)**
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.26	2.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.59	2.85
Urgency of medical decision making	2.74	3.05
Technical Skill/Physical Effort (Mean)		
Technical skill required	1.49	1.51
Physical effort required	1.31	1.31
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.46	2.97
Outcome depends on the skill and judgment of physician	2.64	2.95
Estimated risk of malpractice suit with poor outcome	4.31	3.03

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.44	1.31
Intra-Service intensity/complexity	3.69	3.03
Post-Service intensity/complexity	1.90	1.92

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature reviewed the 90460 survey results. Given the robustness and validity of the data, the AAP recommends the survey median work relative value units of 0.25 and the pre-, intra-, and post-service times of 3 minutes, 7 minutes, and 2 minutes, respectively.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Immunizations are typically administered during the same patient encounter as a separately reported Preventive Medicine Service

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. A 15-year old patient receives the Human Papilloma virus (HPV) vaccine from her physician. The ordering physician discusses the risks of the vaccine and the disease for which it provides protection. The parent/guardian is given the CDC vaccine information sheet (VIS).The parent/guardian consents and the nurse prepares the vaccine. The patient receives the vaccine by a single injection, and the nurse charts the required information and accesses and enters the vaccine data into the statewide immunization registry. The patient is discharged home after the nurse confirms that there are no serious immediate reactions. This service is typically provided in conjunction with a separately reported Preventive Medicine Service.

	CPT Code	Descriptor	Global Period	2009 wRVUs	Pre-Time	Intra-Time	Post-Time
3.							
4.	99394	Prev med serv	XXX	1.36	5	25	5
5.	90649	HPV vaccine	N/A	N/A	N/A	N/A	N/A
6.	90460	Imm admin; first component	XXX	0.25	3	7	2

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90465-90468

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 52232422
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. This estimate is based on a birth cohort managed by pediatricians of 2,843,045 patients and adherence to the ACIP/AAP/AAFP Recommended Immunization Schedule.

Specialty Pediatrics Frequency 52232422 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,033 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Source: 2007 Medicare claims data for code 90465. NOTE: This is a pediatric service not typically provided to Medicare patients.

Specialty Pediatrics Frequency 1033 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 90471 the exisitng immunization administration code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90461 Tracking Number E2 Specialty Society Recommended RVU: **0.18**
Global Period: ZZZ RUC Recommended RVU: **0.16**

CPT Descriptor: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A four-month-old patient receives the diphtheria, tetanus, pertussis, Hemophilus influenza type b, inactivated polio (DTaP-Hib-IPV) combination vaccine from her physician. The ordering physician discusses the risks of each additional vaccine component (eg, tetanus) and the diseases for which each additional vaccine component provides protection. The parent/guardian is given the CDC vaccine information statement (VIS) for each additional vaccine component. The parent/guardian consents for each of the additional vaccine components. The nurse charts the required information and enters data into the statewide immunization registry for each additional vaccine component.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No
Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: .

Description of Intra-Service Work: The physician discusses the specific risks/benefits of each additional vaccine component including the risks associated with each additional component and the risk of not receiving each one to include both health risk from the preventable disease and the social concerns related to school mandates for vaccines. The physician then discusses the benefit of being immunized for each disease and the absence of evidence for risk of brain damage associated with each additional component. The parent's questions regarding the safety and efficacy of giving multiple antigens at one time versus giving the vaccine in single components are addressed. After further discussion, the parent then agrees with need for immunization against each additional disease component. The physician then discusses the care plan for the child in the days to follow specific to the anticipated or possible side effects of each vaccine component.

Description of Post-Service Work: .

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009					
Presenter(s):	Steve Krug, MD, FAAP and Margie Andreae, MD, FAAP					
Specialty(s):	American Academy of Pediatrics (AAP)					
CPT Code:	90461					
Sample Size:	786	**Resp N:**	78	**Response:** 9.9 %		
Sample Type:	Panel **Additional Sample Information:** Sample drawn from membership of the AAP Section on Administration & Practice Management					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	312.50	**750.00**	1500.00	6000.00
Survey RVW:		0.09	0.16	**0.18**	0.25	1.77
Pre-Service Evaluation Time:				**2.50**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		0.00	2.00	**5.00**	5.00	25.00
Immediate Post Service-Time:	**2.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: ZZZ Global Code

CPT Code:	90461	**Recommended Physician Work RVU: 0.16**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		
Immediate Post Service-Time:	**0.00**			
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**		
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**		
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**		
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**		
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**		
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**		

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
96370	ZZZ	0.18	**RUC Time**

CPT Descriptor Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13102	ZZZ	1.24	**RUC Time**	11,931

CPT Descriptor 1 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
13122	ZZZ	1.44	**RUC Time**	13,490

CPT Descriptor 2 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
96375	ZZZ	0.10	**RUC Time**

CPT Descriptor Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 44.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 90461**	**Key Reference CPT Code:** 96370	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**5.00**	**5.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)	**(of those that selected Key Reference code)**	
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.03	1.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.49	2.71
Urgency of medical decision making	2.69	2.89
Technical Skill/Physical Effort (Mean)		
Technical skill required	1.34	1.54
Physical effort required	1.26	1.29
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.60	2.80
Outcome depends on the skill and judgment of physician	2.77	2.91
Estimated risk of malpractice suit with poor outcome	4.49	2.83

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.20	1.37
Intra-Service intensity/complexity	3.57	2.80
Post-Service intensity/complexity	1.89	2.00

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature reviewed the 90461 survey results. Given the robustness and validity of the data, the AAP recommends the survey median work relative value units of 0.18 and the intra-service time of 5 minutes. The AAP recommends the 25th percentiles for the pre- and post-service work times of 1 minute each. Although 9046X2 is a "ZZZ" code (and "ZZZ" codes do not typically

include pre- or post-service times), the AAP recommends pre- and post-service times of 1 minute each due to the additional pre- and post-service associated with each additional (ie, unique) vaccine component administered.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Immunizations are typically administered during the same patient encounter as a separately reported Preventive Medicine Service

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. A four-month old patient receives the diphtheria, tetanus, pertussis, Hemophilus influenza type b, inactivated polio (DTaP-Hib-IPV) combination vaccine from her physician. The ordering physician discusses the risks of each additional vaccine component (eg, tetanus) and the diseases for which each additional vaccine component provides protection. The parent/guardian is given the CDC vaccine information sheet (VIS) for each additional vaccine component. The parent/guardian consents for each of the additional vaccine components. The nurse charts the required information and enters data into the statewide immunization registry for each additional vaccine component.

3.
4. This service is typically provided in conjunction with a separately reported Preventive Medicine Service.

5. CPT Code	Descriptor	Global Period	2009 wRVUs	Pre-Time	Intra-Time	Post-Time
6.						
7. 99391	Prev med serv	XXX	1.02	2	20	4
8. 90698	DTaP-Hib-IPV	N/A	N/A	N/A	N/A	N/A
9.	vaccine					
10. 90460	Imm admin; first component	XXX	0.25	3	7	2
11. 90461	Imm admin; each add'l	ZZZ	0.18	2.50	5	2
12.	component					
13. 90461	Imm admin; each add'l	ZZZ	0.18	2.50	5	2
14.	component					
15. 90461	Imm admin; each add'l	ZZZ	0.18	2.50	5	2
16.	component					
17. 90461	Imm admin; each add'l	ZZZ	0.18	2.50	5	2
18.	component					

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 90465-90468

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 49457611
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This estimate is based on a birth cohort managed by pediatricians of 2,843,045 patients and adherence to the ACIP/AAP/AAFP Recommended Immunization Schedule.

Specialty Pediatrics Frequency 49457611 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 38 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Source: 2007 Medicare claims data for code 90466. NOTE: This is a pediatric service not typically provided to Medicare patients.

Specialty Pediatrics Frequency 38 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 90472 - existing immunization administration code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

8
Tab Number

Immunization Administration
Issue

90461 - 90462
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey and summary of recommendation forms are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

Signature

STEVEN E. KRUG
Printed Signature

American Academy of Pediatrics
Specialty Society

8/5/09
Date

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Facility Direct Inputs

CPT Long Descriptor:
Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature developed the direct practice expense input recommendations for code 90460 using the February 2005 and February 2008 RUC-approved recommendations for code 90465.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

There is a phone call to answer questions/concerns that arise concerning vaccine component reactions that may appear within a few days of the administration

CPT Code: 90461

AMA Specialty Society RVS Update Committee Recommendation

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
XXX Global Period
Non Facility Direct Inputs

CPT Long Descriptor:
Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature developed the direct practice expense input recommendations for code 90460 using the February 2005 and February 2008 RUC-approved recommendations for code 90465.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Clinical staff prepares patient chart with appropriate CDC vaccine information statement (VIS)

Intra-Service Clinical Labor Activities:

- **Clinical staff provides patient/parent with appropriate VIS**
- **Clinical staff follows up on physician's vaccine counseling session with patient/parent and obtains actual consent signature**
- **Clinical staff prepares vaccine, instructs the parent on proper positioning of the patient, selects and prepares the injection site, and administers the vaccine**
- **Clinical staff comforts the patient and directs the patient/parent to remain in the office after the service for about 20 minutes to watch for immediate reactions**
- **Clinical staff cleans room/equipment**
- **Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.**
- **Clinical staff enters data into the state online immunization information system (registry) and maintains the vaccine refrigerator/freezer temperature log**

Post-Service Clinical Labor Activities:

There is a phone call to answer questions/concerns that arise concerning vaccine component reactions that may appear within a few days of the administration

	A	B	C	D	E	F	G
1	**AMA Specialty Society RVS Update Committee Recommendation**			**90460**		**90461**	
2	**Meeting Date: October 2009**	**CMS**	**Staff**	**Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component**		**Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**						
5	**TOTAL CLINICAL LABOR TIME**			**18.0**	**1.0**	**0.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**1.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**16.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**1.0**	**1.0**	**0.0**	**0.0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	**Other Clinical Activity (please specify): Clinical staff prepares patient chart with appropriate CDC vaccine information statement (VIS)**	**L037D**	**RN/LPN /MTA**	**1**			
17	**End: When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
20	**Clinical staff provides patient/parent with appropriate VIS**	**L037D**	**RN/LPN /MTA**	**1**			
21	Greet patient and provide gowning						
22	Obtain vital signs						
23	**Clinical staff follows up on physician's vaccine counseling session with patient/parent and obtains actual consent signature**	**L037D**	**RN/LPN /MTA**	**3**			
24	Prepare room, equipment, supplies						
25	Setup scope (non facility setting only)						
26	Prepare and position patient/ monitor patient/ set up IV						
27	Sedate/apply anesthesia						
28	**Intra-service**						
29	**Clinical staff prepares the vaccine, instructs the parent on proper positioning of the patient, selects and prepares the injection site, and administers the vaccine**	**L037D**	**RN/LPN /MTA**	**4**			
30	**Post-Service**						
31	**Clinical staff comforts the patient and directs the patient/parent to remain in the office after the service for about 20 minutes to watch for immediate reactions**						
32	**Clinical staff cleans room/equipment**	**L037D**	**RN/LPN /MTA**	**1**			
33	Clean Scope						
34	Clean Surgical Instrument Package						
35	Complete diagnostic forms, lab & X-ray requisitions						
36	Review/read X-ray, lab, and pathology reports						
37	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
38	Discharge day management						
39	**Other Clinical Activity (please specify): Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.**	**L037D**	**RN/LPN /MTA**	**3**			
40	**Clinical staff enters data into the state online immunization information system (registry) and maintains the vaccine refrigerator/freezer temperature log**	**L037D**	**RN/LPN /MTA**	**4**			
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						

	A	B	C	D	E	F	G
1	**AMA Specialty Society RVS Update Committee Recommendation**			**90460**		**90461**	
2	**Meeting Date: October 2009**	**CMS**	**Staff**	**Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component**		**Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
44	**There is a phone call to answer questions/concerns that arise concerning vaccine component reactions that may appear within a few days of the administration**	**L037D**	**RN/LPN /MTA**	**1**	**1**		
45	*Office visits:*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	*Total Office Visit Time*			**0**	**0**	**0**	**0**
54	Other Activity (please specify)						
55	**End: with last office visit before end of global period**						
56	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
57	**Gloves, non-sterile**	**SB022**	**1 pair**	**0.5**			
58							
59	**Syringe w/needle, OSHA compliant (SafetyGlide)**	**SC058**	**1 item**	**1**			
60	**Swab-pad, alcohol**	**SJ053**	**1 item**	**2**			
61	**Bandage, strip 0.75in x 3in (Bandaid)**	**SG021**	**1 item**	**1**			
62	**CDC information sheet**	**SK012**	**1 item**	**1**			
63	**Equipment**	**CMS Code**					
64	**Table, exam**	**EF023**					
65	**Refrigerator, vaccine, commercial grade, w/alarm lock**	**Row 63 of CMS spread-sheet**		**16.0**			
66	**Refrigerator, vaccine, temperature monitor w-alarm, security mounting w/sensors, NIST certificates**	**Row 41 of CMS spread-sheet**		**16.0**			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
October 2009

H1N1 Immunization Administration

At the request of the Department of Health and Human Services, the CPT Editorial Panel created a new code 90470 *H1N1 immunization administration (intramuscular, intranasal), including counseling when performed* to assist the public health effort to immediately vaccinate for H1N1. The Centers for Medicare and Medicaid Services (CMS) asked the RUC to immediately review the new service and provide recommendations on the estimated physician work and direct practice expense inputs anticipated to be required to provide the immunization. The American Academy of Family Physicians, American Academy Pediatrics, American College of Obstetricians and Gynecologists, and American College of Physicians provided information for the RUC to review on October 3.

The RUC reviewed newly described immunization services for children at the October meeting and was persuaded that physician efforts related to counseling for immunization has increased. The RUC agreed that increased attention to vaccine safety on the Internet and other media has driven anxiety and have necessitated additional physician involvement and discussion with parents. The RUC recommends that the same level of physician work, for many adults and children, will also be necessary as the H1N1 vaccine becomes available. The RUC agreed that immunization administration for H1N1 should be valued higher than the routine immunization administration code 90471 (0.17) as high risk individuals must first be identified and patients are more likely to have questions about this vaccine and the H1N1 epidemic. **The RUC recommends a physician work value of 0.20 and intra-service time of 7 minutes for 90470 *H1N1 immunization administration.***

Practice Expense: The RUC recommends that the practice expense inputs for H1N1 be equivalent to the pediatric immunization codes reviewed at the October 2009 meeting and 90471 with two primary exceptions. First, an additional two minutes of staff time should be added to capture the additional work of identifying and contacting patients as the vaccine is provided by the State. In addition, these patients may come to this service only, and therefore, the standard greet patient time of 3 minutes should also be added. The total clinical staff time should be 23 minutes.

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU
●90470	H1N1 immunization administration (intramuscular, intranasal), including counseling when performed	XXX	0.20

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:90470 Tracking Number Specialty Society Recommended RVU: **0.20**
Global Period: XXX RUC Recommended RVU: **0.20**

CPT Descriptor: H1N1 immunization administration (intramuscular, intranasal), including counseling when performed

---

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient, who has been identified by the CDC guidelines as being appropriate for H1N1, is notified that their condition requires prophylactic vaccination for H1N1, and presents at the physician office.

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: A patient, who has been identified by the CDC guidelines as being appropriate for H1N1, is notified that their condition requires prophylactic vaccination for H1N1, and presents at the physician office. In accordance with national recommendations for immunizations, the physician determines that the patient should receive a novel H1N1 influenza vaccination. The patient/parent/guardian is asked about any previous immunization reactions and is given the CDC vaccine information sheet (VIS) on novel H1N1 influenza. The physician reviews the benefits and risks of providing the novel H1N1 influenza vaccination with the patient/parent/guardian. After consent, the physician directs the nurse to give the patient the novel H1N1 influenza immunization as an injection or intranasally. The immunization tracking number is entered into a computerized statewide registry and other federal tracking and other requirements are followed by the physician office.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2009				
Presenter(s):	George Hill MD; Margie Andrae MD; Steve Krug MD; Tom Weida MD				
Specialty(s):	American College of Physicians; American Academy of Pediatrics; American Academy of Family Physicians; American College of Obstetrics and Gynecology				
CPT Code:	90470				
Sample Size:	0	**Resp N:** 0	**Response:** 0.0 %		
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:					
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:			**0.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	90470	**Recommended Physician Work RVU: 0.20**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**7.00**	**-7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**7.00**		

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? Yes

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
9046X1	XXX	0.20	**RUC Time**

CPT Descriptor [The 9046X1 value has not yet been voted on by RUC.]
Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,242,167

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36405	XXX	0.31	**RUC Time**	14

CPT Descriptor 2 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

Other Reference CPT Code	Global	Work RVU	Time Source
	XXX		**RUC Time**

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 90470**	**Key Reference CPT Code:** 9046X1	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	7.00	7.00	
Median Immediate Post-service Time	0.00	0.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	**7.00**	**7.00**	

Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered		
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed		
Urgency of medical decision making		

Technical Skill/Physical Effort (Mean)

Technical skill required		
Physical effort required		

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality		
Outcome depends on the skill and judgment of physician		
Estimated risk of malpractice suit with poor outcome		

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

Additional Rationale

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Please see the attachments.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) not applicable -- this is a new service

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty How often?

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? CDC estimates that 40 million doses may be given during the 2009-2010 flu season.
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 90471

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

Rationale:

This recommendation is the result of an urgent request for an expedited RUC review.

At the request of the United States Department of Health and Human Services (see attached), the CPT Editorial Panel reviewed an urgent request to create specific CPT codes for the H1N1 immunization administration and vaccine. The Panel approved this request today. CMS has requested that the RUC conduct an expedited review of this service and submit recommendations to the agency immediately following the RUC meeting next week. CMS will consider the RUC's recommendation and publish the final valuation in the Final Rule for the 2010 Medicare Physician Payment Schedule, expected to be published in the Federal Register in early November.

On September 24, 2009, prior to any written documentation, Sherry Smith of AMA staff personally contacted each of the affected specialty societies (ACP, AAFP, AAP, and ACOG) by telephone, requesting quick action on a Level of Interest form. She explained that the CPT Editorial Panel had just approved new codes for reporting services related to novel H1N1 in the upcoming influenza season.

CMS has already released G codes and payment policy for H1N1 immunization administration and it is not yet determined whether the RUC's recommendations related to the new CPT code will impact this existing policy. (For your reference, please see the attached letters between Dr. Maves and Secretary Sebelius with several AMA recommendations regarding payment policy for the H1N1 vaccine administration.)

RUC staff notified ACP, AAFP, AAP, and ACoG via e-mail to request our individual levels of interest in developing work relative value recommendations and direct practice expense inputs for new CPT code 90470 to be provided to the AMA RUC staff by Thursday, October 1. The RUC was scheduled to review the recommendations the following week.

Staff at each society immediately marshaled their RUC Advisors into the activity of deciding how to handle this expedited RUC review. Because there was insufficient time to conduct a formal RUC survey, the societies decided – independently – that it would be most efficient if each society's RUC Advisors and other physician advisory panel members would review and discuss the code proposal and related documents, arrive at a recommended value, and then coordinate among all the affected societies to determine a joint recommendation.

We jointly recommend a crosswalk from the 9046X1 (*Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component* recommended relative physician work RVU (0.20). This is an appropriate code to reference, due to 9046X1's and 90470's similarity in physician work. 9046X1 was surveyed by the American Academy of Pediatrics for presentation at the October 2009 RUC meeting; we believe that its survey results are reflective of what would have been obtained for 90470, if a survey for the H1N1 administration code had been possible.

Overall and Medicare utilization of CPT code 90470 is unknown at this time, but we expect that the code usage will be in the millions, as the US Department of Health and Human Services and the Centers for Disease Control estimates that 40 million doses will be needed for the 2009-2010 influenza season.

	A	B	C	D	E	F	G
1	**H1N1 Immunization Administration**			**90470**			
2	**October 2009 RUC Recommendations**	**CMS**	**Staff**	**H1N1 immunization administration (intramuscular, intranasal), including counseling when performed**			
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**		
4	**GLOBAL PERIOD**						
5	**TOTAL CLINICAL LABOR TIME**			**23.0**	**1.0**		
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**3.0**	**0.0**		
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**19.0**	**0.0**		
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**1.0**	**1.0**		
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	**Other Clinical Activity (please specify): Identify and contact appropriate patients and schedule immunization**	**L037D**	**RN/LPN /MTA**	**2**	**0**		
17	**Other Clinical Activity (please specify): Clinical staff prepares patient chart with appropriate CDC vaccine information statement (VIS)**	**L037D**	**RN/LPN /MTA**	**1**	**0**		
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
21	**Greet patient and provide gowning**			**3**	**0**		
22	Obtain vital signs						
23	**Clinical staff provides patient/parent with appropriate VIS**	**L037D**	**RN/LPN /MTA**	**1**	**0**		
24	**Clinical staff follows up on physician's vaccine counseling session with patient/parent and obtains actual consent signature**	**L037D**	**RN/LPN /MTA**	**3**	**0**		
25	Prepare room, equipment, supplies						
26	Setup scope (non facility setting only)						
27	Prepare and position patient/ monitor patient/ set up IV						
28	Sedate/apply anesthesia						
29	**Intra-service**						
30	**Clinical staff prepares the vaccine, instructs the patient/parent on proper positioning of the patient, selects and prepares the injection site, and administers the vaccine**	**L037D**	**RN/LPN /MTA**	**4**	**0**		
31	**Post-Service**						
32	Clinical staff comforts the patient and directs the patient/parent to remain in the office after the service for about 20 minutes to watch for immediate reactions	L037D	RN/LPN /MTA	0	0		
33	**Clinical staff cleans room/equipment**	**L037D**	**RN/LPN /MTA**	**1**	**0**		
34	Clean Scope						
35	Clean Surgical Instrument Package						
36	Complete diagnostic forms, lab & X-ray requisitions						
37	Review/read X-ray, lab, and pathology reports						
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
39	Discharge day management						
40	**Other Clinical Activity (please specify): Clinical staff enters vaccine information into the patient medical record to include the vaccine type, lot number, site, date of administration, and date of VIS as required by federal law. A final check of the patient is done to confirm that there are no serious immediate reactions and final questions are answered.**	**L037D**	**RN/LPN /MTA**	**3**	**0**		
41	**Clinical staff enters data into the state online immunization information system (registry) and maintains the vaccine refrigerator/freezer temperature log**	**L037D**	**RN/LPN /MTA**	**4**	**0**		
42	**End: Patient leaves office**						

	A	B	C	D	E	F	G
1	**H1N1 Immunization Administration**			**90470**			
2	**October 2009 RUC Recommendations**	**CMS**	**Staff**	**H1N1 immunization administration (intramuscular, intranasal), including counseling when performed**			
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**		
43	**POST-SERVICE Period**						
44	**Start: Patient leaves office/facility**						
45	**There is a phone call to answer questions/concerns that arise concerning vaccine component reactions that may appear within a few days of the administration (assumes physician office will receive a phone call from approximately 1 out of every 3 patients/parents)**	**L037D**	**RN/LPN /MTA**	**1**	**1**		
46	*Office visits:*						
47	*List Number and Level of Office Visits*						
48	99211 16 minutes		16				
49	99212 27 minutes		27				
50	99213 36 minutes		36				
51	99214 53 minutes		53				
52	99215 63 minutes		63				
53	Other						
54	*Total Office Visit Time*			**0**	**0**		
55	Other Activity (please specify)						
56	**End: with last office visit before end of global period**						
57	**MEDICAL SUPPLIES**	**CMS Code**	**Unit**				
58	**Gloves, non-sterile**	**SB022**	**1 pair**	**1**	**0**		
59	**Paper, exam table**	**SB036**	**1 foot**	**7**	**0**		
60	**Syringe w/needle, OSHA compliant (SafetyGlide)**	**SC058**	**1 item**	**1**	**0**	**Limited information suggests that the vaccine may be come with syringe and alcohol swab pad. CMS should confirm and delete supply if it will be provided to all physicians for free.**	
61	**Swab-pad, alcohol**	**SJ053**	**1 item**	**2**	**0**		
62	**Bandage, strip 0.75in x 3in (Bandaid)**	**SG021**	**1 item**	**1**	**0**		
63	**CDC information sheet**	**SK012**	**1 item**	**1**	**0**		
64	**Equipment**	**CMS Code**					
65	**Table, exam**	**EF023**	**CMS to compute**				
66	**Refrigerator, vaccine, commercial grade, w/alarm lock**	**Row 63 of CMS spread-sheet**	**CMS to compute**				
67	**Refrigerator, vaccine, temperature monitor w-alarm, security mounting w/sensors, NIST certificates**	**Row 41 of CMS spread-sheet**	**CMS to compute**				

New Vignette for 90470

A 35-year-old female with a history of asthma is notified that her condition requires prophylactic vaccination for H1N1, and presents at the local clinic.